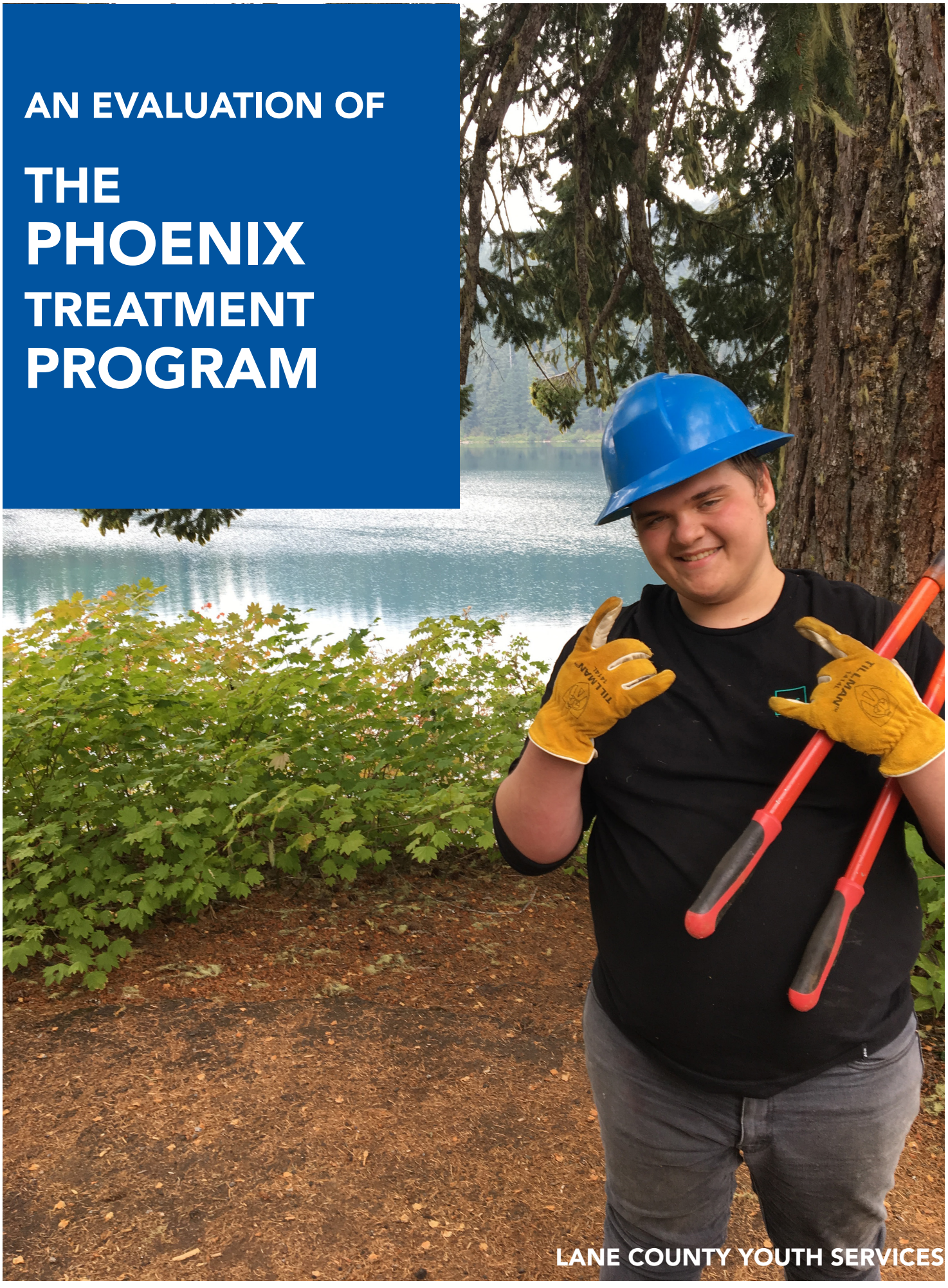
AN EVALUATION OF

# THE PHOENIX TREATMENT PROGRAM




LANE COUNTY YOUTH SERVICES

## About Lane County Youth Services

"Lane County Youth Services' mission is to reduce juvenile crime through coordinated prevention and intervention programs that hold justice-involved youth appropriately accountable; provide restorative, rehabilitative and treatment services for youth and their families using evidence based practices and data driven decision making; promote healthy family interactions; prevent, reduce, and resolve family conflict; protect victims' rights during all phases of Court proceedings; and safeguard our communities"

(Lane County website: https://www.lanecounty.org)

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# INTRODUCTION

**THE LANE COUNTY YOUTH SERVICES PHOENIX TREATMENT PROGRAM IS A COGNITIVE-BEHAVIORALLY-BASED CO-ED RESIDENTIAL TREATMENT PROGRAM FOR YOUTH AGES 12 TO 17 WHO HAVE AN ACTIVE CASE WITH LANE COUNTY YOUTH SERVICES, AND WHO HAVE BEEN UNSUCCESSFUL IN LESS RESTRICTIVE ENVIRONMENTS**

## INTRODUCTION

This was a summative program evaluation of the Lane County Youth Services Phoenix Treatment Program, a cognitive-behaviorally based co-ed residential treatment program for youth ages 12 – 17 years who have an active case with Lane County Youth Services, and who have been unsuccessful in less restrictive environments.

The evaluation contains both quantitative and qualitative data to provide a richer and more detailed description of the Phoenix Treatment Program and its complex processes that involve numerous stakeholders. In broad terms, the evaluation examined the program since its inception in 2005 through 2018—a sizable task. More narrowly, the evaluation compared outcomes of youth who participated in the program during 2017 with outcomes of youth who did not participate in the program in 2017. In addition, qualitative data are included for years 2017 -2018 for the purposes of adding context to the attitudes, perceptions and experiences of the youth and families who participated in the program, as well as the attitudes, perceptions and experiences of Lane County Youth Services staff who worked with the youth and families during that time.

## THE EVALUATION

The evaluation was completed by an internal evaluator hired by Lane County Youth Services, who started the project in April 2018 and completed the report in May 2019. The evaluation was completed in 550 hours of work.

Stufflebeam's CIPP management-oriented evaluation framework was used to organize the evaluation work into four areas: context, inputs, process, and products (outcomes) (Stufflebeam, 1971). This management-oriented approach was intended to serve decision-makers, and address their concerns and needs. The decision-maker's criteria for effectiveness guided the direction of the study throughout the process—that is, the evaluator met regularly with decision-makers to check in and confirm that the work was proceeding in an acceptable

THE EVALUATION WAS ORGANIZED INTO FOUR MAIN AREAS:

CONTEXT

INPUTS

PROCESS

OUTCOMES

manner. Along the way, small adjustments were made to accommodate the decision-maker's needs and to adjust to changes that were happening in the Phoenix Treatment Program (for example, there were several program director changes during the evaluation). In this way, the program evaluation was a cooperative and collaborative effort—the evaluator did not lock himself in a dark room for a year and magically emerge with the evaluation report.

Eleven evaluation questions were developed during the initial phase of the evaluation, in coordination with Lane County Youth Services administrators, Phoenix Treatment Program Supervisors, front-line staff, and Juvenile Counselors. There were some adjustments to the evaluation questions during the initial phase. Once finalized, the evaluation questions guided the work during the year.

## DATA COLLECTION

Data were collected from a variety of sources throughout the evaluation including quantitative information from existing records and documents, as well as qualitative data obtained from direct observations and semi-structured interviews with Phoenix Treatment Program staff, youth and families, and other juvenile directors from various counties in the state of Oregon.

A quasi-experimental nonequivalent comparison group design was used for part of the evaluation to determine pre and post performances of the 33 youth who participated in the Phoenix Treatment Program during 2017 compared with the 80 adjudicated youth who did not participate in the program in 2017.

## DATA ANALYSIS

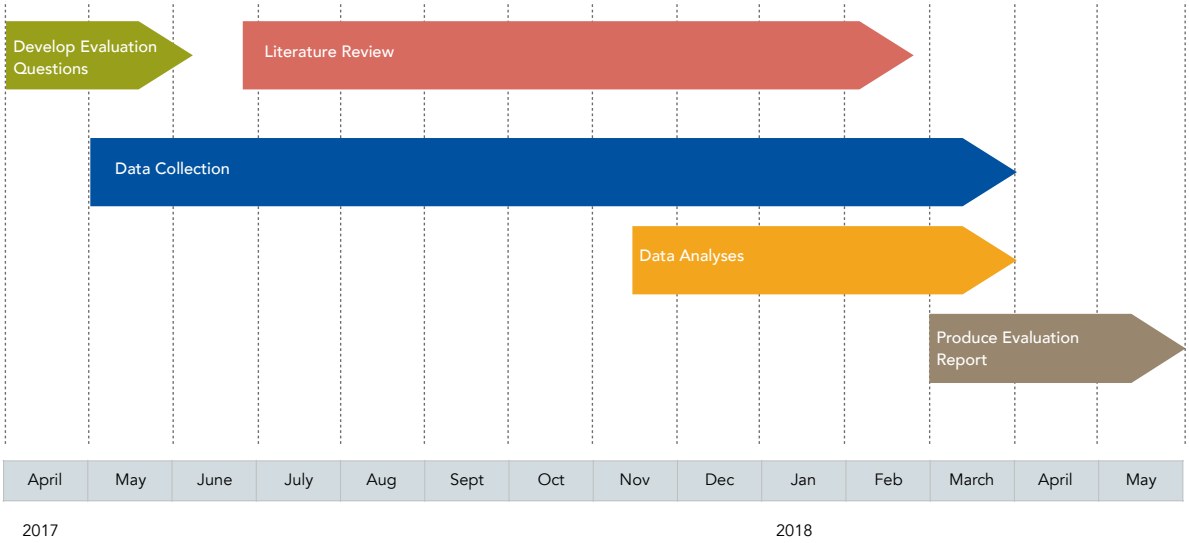
Data were analyzed in a variety of ways depending on the characteristics of the data. Quantitative data were analyzed using simple descriptive statistics such as frequency, percentage, and mean (the small sample size of Phoenix Treatment Program youth did not allow for inferential statistical methods). Qualitative data were analyzed by an inductive content analysis process that identified important coherent themes and patterns in the data (Patton, 2002).

## LITERATURE REVIEW

A review of the academic literature was completed in order to ground the Phoenix Treatment Program in the scientific literature, to provide context for the numerous components of the program, and to point towards ways in which the Phoenix Treatment Program might change to align more closely with best practices.

The evaluation report is separated into 11 chapters: Introduction, Executive Summary, Evaluation Framework, Evaluation Questions, Background Information, Description of the Phoenix Treatment Program, Phoenix Treatment Program Outcomes, Key Findings, Recommendations, Literature Review, and Appendices.

## PHOENIX TREATMENT PROGRAM EVALUATION TIMELINE




## PROFESSIONAL STANDARDS

It is important to note that this program evaluation was not a scientific research study. Instead, the work was governed by the Joint Committee on Standards for Educational Evaluation (Yarbrough, Shulla, Hopson, & Caruthers, 2011). The standards included 19 criteria for professional program evaluators. A summary of the standards is included in the Appendices.

## THE PHOENIX TREATMENT PROGRAM

After reviewing this evaluation, the reader should understand that the Phoenix Treatment Program is an incredibly complex program that provides important cognitive behavioral services for youth and their families who are deeply involved in the juvenile justice system. The evaluation documents the good work done by the dedicated professional staff, and the positive outcomes for the youth who participated in the program in 2017. Several findings are noted, as well as recommendations for changes to consider as the program moves forward.

> THE DIFFERENCE BETWEEN RESEARCH AND EVALUATION IS THAT RESEARCH SEEKS *CONCLUSIONS*. EVALUATION *LEADS TO JUDGEMENT* BY DESCRIBING *ALL* OF THE FEATURES OF A PROGRAM
>
> FITZPATRICK, SANDERS, & WORTHEN (2004)

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# EXECUTIVE SUMMARY

**THIS EVALUATION IS A TRIBUTE TO THE YOUTH AND FAMILIES WHO HAVE PARTICIPATED IN THE PHOENIX TREATMENT PROGRAM SINCE 2005. THEIR HARD WORK, SUCCESSES, AND SOMETIMES FAILURES ARE IMPORTANT TO EVERYONE IN LANE COUNTY BECAUSE THEIR FUTURES ARE CRITICAL TO THE COLLECTIVE FUTURE OF OUR COMMUNITY. THESE KIDS ARE OUR KIDS AND WE SHOULD MAKE EVERY EFFORT TO HELP THEM SUCCEED**

## EXECUTIVE SUMMARY

This report describes the Lane County Youth Services Phoenix Treatment Program evaluation that was completed in 2019. The Phoenix Treatment Program is part of a spectrum of services that are provided to youth accused of law violations or judged delinquent by the juvenile court. It is a narrowly targeted intervention for youth (boys and girls) ages 12 – 17 that have an active case with Lane County Youth Services--typically these youth are on formal court probation for a felony or Class A person-to-person misdemeanor and are considered high risk to commit more crimes. In most cases, the youth have been unsuccessful living at home.

In clinical terms, the Phoenix Treatment Program is a cognitive behavioral focused 16-bed residential treatment program for youth with behavioral and emotional disorders. But that description misses the mark because talks about kids as if they were patients, or numbers, or descriptions from a psychology textbook.

A better description of the Phoenix Treatment Program is that it changes lives of the young people who participate in its rigorous and often emotional hard work of repairing themselves and their families—to a place where healthy relationships are learned, practiced, and always encouraged by the professionals who work in the program. There are a lot of people who work the youth in the Phoenix Treatment Program including front-line Group Workers, Juvenile Counselors, Mental Health Therapists, Drug and Alcohol Counselors, Education Specialists, and Vocational Specialist--and every single one is dedicated to helping youth learn the skills to live successfully outside of the program and return to their homes, families, friends, and schools.

People often confuse the differences between a program evaluation and a research study. The differences are stark, and it is important for the reader to understand why an evaluation is more inclusive (and perhaps more useful) than a scientific research study. If one thinks of a large family meal occasion, a research study might look at a

narrow view, for example what are the effects of whipped cream on the satisfaction rating of the pumpkin pie—interesting perhaps, but not very useful in describing the entire meal.

A program evaluation would look at the entire meal—from beginning to end—and describe the details of every element. How did people arrive? Who was there? What were people wearing? Who wasn't there? Why did you have to sit next to Aunt Beatrice? What did the meal contain, who prepared it, what plates were used, what did it smell like, what were the perceptions and experiences of the people attending?—and so on. Whereas research seeks conclusions, program evaluation leads to judgement.

And that is what the reader should gain by reading this report--a judgement that the Phoenix Treatment Program is an incredibly complex and effective intervention for youth who are trying to find their way back to positive life choices and healthy relationships. Most readers will quickly flip through the pages to find information about recidivism because that is how juvenile justice interventions have traditionally been judged. Those readers will be glad to know that in 2017, youth who participated in the Phoenix Treatment Program recidivated less compared to similar youth who did not participate in the Phoenix Treatment Program. In fact, the Phoenix youth recidivism rate was lower than the overall Lane County rate, and lower than the overall state of Oregon rate in 2017.

For readers who are interested in more strength-based measures of youth success, they will be pleased to know that about 60% of youth who participated in the Phoenix Treatment Program in 2017 were successfully living at home after completing the program. The report also contains qualitative data that describes the experiences, perceptions and attitudes of the people in the program. The important voices of the youth and their families are included, as well as the voices of the professionals who work with the youth and families on a day to day basis.

Readers will also find a review of the academic literature regarding best practices in residential treatment for youth involved in the juvenile justice system. The literature highlights the elements of best practices and the review is intended to provide a theoretical grounding of the Phoenix Treatment Program. Any changes to the program moving forward should connect strongly with the evidence included in the literature. One of the strongest threads of evidence in the literature has to do with the "negative peer contagion" effect that Tom Dishion and his colleagues wrote so elegantly about. In simple terms, the negative peer contagion effect means that high risk youth have a negative effect on low risk youth if they are in the same program together. This concept should be kept in mind as changes to the Phoenix Treatment Program are considered.

Another strong body of evidence in the literature speaks to the developmental process that leads many young people to stop committing crimes as they get older. This has a lot to do with normal brain development. The teenage brain is not fully developed which makes adolescents more susceptible to recklessness, sensation-seeking behaviors and risk-taking compared to adults. As teenagers approach their mid-twenties, the parts of their brains that encourage thinking about future consequences are more fully developed, which results in better decisions and less criminal activity. It's almost like the best juvenile justice intervention might be to get youth safely through their brain development years and then let their fully mature brains lead the way.

Of course with any program, there are things that could be improved and the Phoenix Treatment Program is no

exception. The program has been underutilized since it began in 2005. During the past five years, the utilization rate has hovered around 60% of capacity. There are various reasons for this, not the least was a significant decline in the number of referrals (criminal acts that resulted in a police report) to Lane County Youth Services during that time. In other words, the "flow" into the Phoenix Treatment Program was extremely narrow, and the sheer number of youth who were available and deemed a good fit for the program was small.

There are other issues for administrators and policy-makers to consider, such as offering gender-specific treatments for girls because the latest research suggests that girls in the juvenile justice system have unique and more complex needs compared to boys, and that placing girls in co-ed programs can have unintended negative effects on girls. The reader is encouraged to review the recommendations for improvement included in this report for more suggestions.

This report is intended to demonstrate the value of the Phoenix Treatment Program and to give the reader a good indication that the program is working as intended. Ultimately, the Phoenix Treatment Program is about people—boys and girls who have complicated trauma histories, antisocial behaviors, addictions, and sometimes negative experiences with adults in their lives who have, for whatever reasons, not been able to be positive role models for their children. The role that trauma plays in the lives of youth in the program should not be underestimated, and readers should come away with deeper understanding about the negative effects of trauma.

Hopefully that deeper understanding will help change the narrative of asking youth "why did you do that?" to "what happened to you? Properly addressing trauma in treatment programs such as the Phoenix Treatment Program is an indication of a change in how the juvenile justice system responds to crime, and demonstrates a "smart on crime" approach based on rehabilitation as opposed to a "tough on crime approach" which is based on punishment and control. By the way, if anyone is looking, our society's "tough on crime" approach in the past hasn't exactly worked out very well, and "smart on crime" approaches hold the promise of better outcomes for youth.

Finally, this report is a tribute to the youth and families who participate in the Phoenix Treatment Program. Their hard work, their successes and sometimes their failures are important for everyone who lives in Lane County because their futures are critically important to our community's collective future. These kids are our kids, and we should make every effort to help them succeed. The Phoenix Treatment Program is one of those ways.

THE ROLE THAT PREVIOUS TRAUMA PLAYS IN THE LIVES OF YOUTH IN THE PHOENIX TREATMENT PROGRAM SHOULD NOT BE UNDERESTIMATED

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# EVALUATION FRAMEWORK

**A THREE-STEP PROCESS WAS USED TO GUIDE THE EVALUATION WORK: 1. DEVELOPING EVALUATION QUESTIONS, 2. CHOOSING AN EVALUATION APPROACH, AND 3. IDENTIFYING DATA SOURCES/APPROPRIATE ANALYSES. THE EVALUATOR WORKED COLLABORATIVELY WITH YOUTH SERVICES PERSONNEL IN THE EARLY STAGES OF THE EVALUATION TO REFINE THE FRAMEWORK. THE "CIPP" MODEL WAS SELECTED AS THE EVALUATION TEMPLATE. CIPP STANDS FOR "CONTEXT," "INPUTS, "PROCESS," AND "PRODUCTS"**

## DEVELOPING EVALUATION QUESTIONS

The evaluation questions were developed following Cronbach's (1982) two-phase process including a "divergent" and "convergent" process which included a discussion of the criteria used to demonstrate the characteristics of a successful residential treatment center for juvenile-justice involved youth. Standards were then developed from various sources including Lane County Youth Services, Oregon Youth Authority, and national standards of performance (Worthen, Sanders, & Fitzpatrick, 1997).

## DIVERGENT PHASE

In the divergent phase, the evaluator obtained input from several sources, including the Lane County Youth Services Division Manager, Juvenile Counselors, Supervisors and program staff. The purpose of the divergent phase was to develop a laundry list of potential evaluation questions and concerns so that a broad view of the possible evaluation scope was obtained.

During the divergent phase, the evaluator sought to better understand the values of the stakeholders, hear about any concerns with the evaluation, what the desired topics of inquiry were, and any curiosities about the Phoenix Treatment Program effectiveness. Also during the divergent phase, the evaluator communicated with the stakeholders about possible evaluation frameworks, the salient issues raised in the academic literature regarding juvenile justice residential treatment programs, and the professional standards that guide program evaluation (Fitzpatrick, Sanders, & Worthen, 2004). The evaluator spent considerable effort to communicate to the stakeholders that the purpose of the evaluation was to document the value of the program, and the fact that the evaluation would not be a scientific research study. Involving the stakeholders in this phase of the evaluation is generally thought to increase the validity and reliability of the evaluation (Brandon, Lindberg, & Wang, 1993).

## TABLE 1: LIST OF EVALUATION QUESTIONS

**CONTEXT**

- What is the national, state, and local context of Lane County's juvenile justice system?
- What is the theoretical foundation of the Phoenix Treatment Program?
- How does the Phoenix Treatment Program compare with other similar programs?
- How does the Phoenix Treatment Program fit in with other Lane County juvenile justice programs or services?

**INPUTS**

- What are the inputs to the Phoenix Treatment Program?

**PROCESS**

- What are the components of the Phoenix Treatment Program?
- What are the processes by which youth are referred to the Phoenix Treatment Program?
- What are the experiences of the youth in the Phoenix Treatment Program?
- What are the experiences of the families in the Phoenix Treatment Program?
- What are the experiences of the staff that work with youth in the Phoenix Treatment Program?

**PRODUCTS**

- What are the outcomes of the Phoenix Treatment Program?

## CONVERGENT PHASE

In the convergent phase of developing the evaluation questions, the evaluator worked with stakeholders to identify the essential questions. A series of informal interviews were conducted with the Director, Juvenile Court Counselors, and Phoenix Treatment Program staff to narrow down the list of potential questions. There was a strong consensus to answer questions regarding the program effectiveness, efficiencies, comparisons with other similar programs, the use of best practices, and ways to improve the program.

## MANAGEMENT ORIENTED "CIPP" MODEL

The evaluator proposed a management-oriented evaluation approach (CIPP) that would capture information regarding program Context, Inputs (resources), flow (Process) through the program, and outcomes (Products). The stakeholders agreed with the evaluation approach, and the evaluator created 11 evaluation questions that addressed the stakeholder's needs, and also fit within the proposed management-oriented evaluation framework. A summary of the evaluation questions is shown in Table 1.

## DATA SOURCES AND ANALYSIS

After the 11 evaluation questions were finalized, the evaluator developed a matrix describing the potential data sources for each question and the appropriate data analysis processes. A summary of the data sources and analyses is shown in Table 2.

## TABLE 2: EVALUATION QUESTIONS, DATA SOURCES AND DATA ANALYSIS

| EVALUATION QUESTIONS | DATA SOURCES | METHOD | DATA ANALYSIS |
|---|---|---|---|
| CONTEXT | | | |
| 1. What is the national, state, and local context of Lane County's juvenile justice system | • Academic/Scientific literature<br>• Phoenix Treatment Program existing information<br>• Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Juvenile Court staff<br>• Juvenile justice staff from other counties in Oregon<br>• Center for Family Development staff | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis |
| 2. What is the theoretical foundation of the Phoenix Treatment Program? | • Academic/Scientific literature<br>• Phoenix Treatment Program existing information<br>• Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Center for Family Development staff | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis |
| 3. How does the Phoenix Treatment Program compare with other similar programs? | • Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Juvenile justice staff from other counties in Oregon | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis |
| 4. How does the Phoenix Treatment Program fit in with other Lane County juvenile justice programs or services? | • Phoenix Treatment Program existing information<br>• Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Juvenile Court staff | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis |
| INPUTS | | | |
| 1. What are the inputs to the Phoenix Treatment Program? | • Phoenix Treatment Program existing information<br>• Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Juvenile Court staff<br>• MLK Education Center staff<br>• Center for Family Development staff | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis |
| PROCESS | | | |
| 1. What are the components of the Phoenix Treatment Program? | • Phoenix Treatment Program existing information<br>• Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Juvenile Court staff<br>• MLK Education Center staff<br>• Center for Family Development staf | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis |
| 2. What are the processes by which youth are referred to the Phoenix Treatment Program? | • State of Oregon Juvenile Justice Information System (JJIS)<br>• Existing literature<br>• Phoenix Treatment Program existing information<br>• Phoenix Treatment Program staff<br>• Lane County Youth Services staff<br>• Juvenile Court staff<br>• MLK Education Center staff<br>• Center for Family Development staff | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis<br><br>Quantitative statistics: Frequency, Percentages |
| 3. What are the experiences of the youth in the Phoenix Treatment Program? | • Youth in the Phoenix Treatment Program<br>• Phoenix Treatment Program staff | Qualitative interviews | Thick written descriptions and qualitative analysis |
| 4. What are the experiences of the families in the Phoenix Treatment Program? | • Families in the Phoenix Treatment Program<br>• Phoenix Treatment Program staff | Qualitative interviews | Thick written descriptions and qualitative analysis |
| 5. What are the experiences of the staff that work with youth in the Phoenix Treatment Program? | • Phoenix Treatment Program staff | Qualitative interviews | Thick written descriptions and qualitative analysis |
| PRODUCTS | | | |
| 1. What are the outcomes of the Phoenix Treatment Program? | • State of Oregon Juvenile Justice Information System (JJIS)<br>• Phoenix Treatment Program staff | Review of existing literature/ information<br><br>Qualitative interviews | Thick written descriptions and qualitative analysis<br><br>Quantitative statistics: Frequency, Percentages |

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# BACKGROUND INFORMATION

**LANE COUNTY YOUTH SERVICES HAS EVOLVED OVER THE YEARS AND HAS BEEN PROFOUNDLY AFFECTED BY NATIONAL TRENDS IN JUVENILE JUSTICE THAT HAVE OSCILLATED BETWEEN "TOUGH ON CRIME" AND "SMART ON CRIME." THE PHOENIX TREATMENT PROGRAM HAS CHANGED ACCORDINGLY. PERHAPS THE MOST SIGNIFICANT CHANGE WAS JULY 2017 WHEN THE PROGRAM MOVED FROM A SECURE LOCATION TO A RESIDENTIAL SETTING**

## A BRIEF HISTORY OF THE JUVENILE COURT

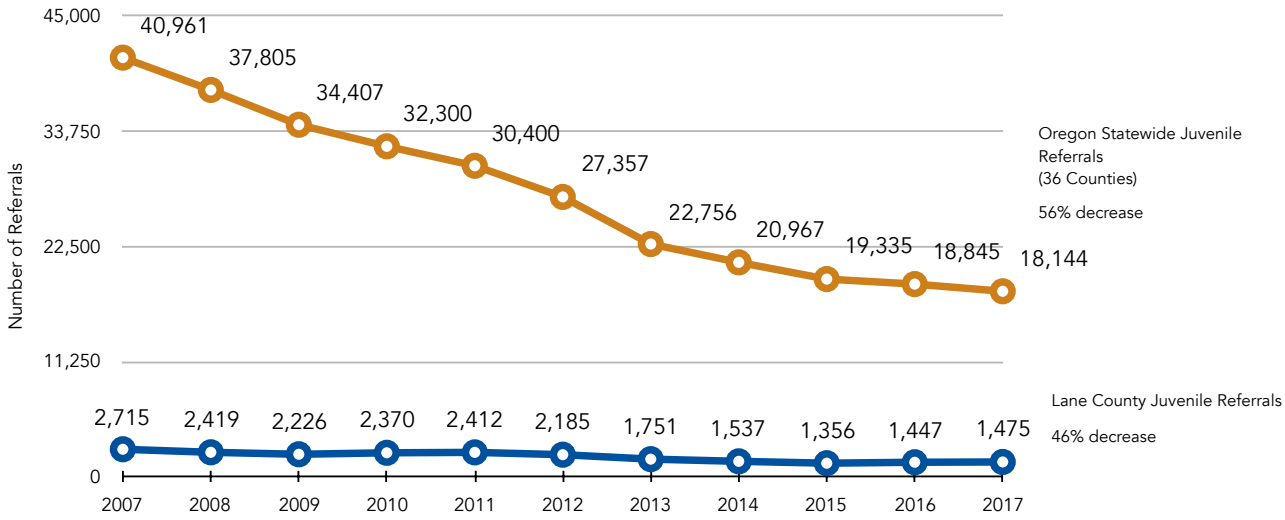
Since beginning in the early 1900's, the Juvenile Court has experienced numerous policy shifts that for the most part, moved back and forth along a continuum of philosophies. While the philosophy of the juvenile justice system was generally accepted as having three components, Community Safety, Accountability, and Rehabilitation (Maloney, 2007), there were (and continue to be) two distinct camps within that philosophy. One end of the continuum encompasses the Juvenile Court's original philosophy that recognized kids are different than adults, are generally more amenable to treatment and rehabilitation, should not be labeled as criminals, and that effective interventions should address their individual, age, gender, racial and cultural needs. On the other end of the continuum is the philosophy that "if you do the crime, you do the time." This generalized over-simplified continuum has been referred as "Smart on Crime" versus "Tough on Crime," and public sentiment and political efforts have cycled back and forth along the continuum during the past 100 years, depending on the particular social, political, economic, and racial influences happening at the time.

## ADOLESCENT BRAIN DEVELOPMENT

Recent advances in knowledge about adolescent brain development and the ecological influences on the development of criminal behavior have added support to returning to the Juvenile Court's original charge—that kids are not merely little adults and their needs should be addressed from a "Smart on Crime" perspective. As a result, the policy pendulum seems to be in a sustained arc towards the Juvenile Court's original intent, and changes to the ways in which juveniles experience the Juvenile Court have swept across the nation in the past 20 years. Now, science is backing up the basic premise of the Juvenile Court and has begun to address the "awkward blend of civil and criminal law" that has plagued the Juvenile Court for decades (National Research Council, 2013).

The growing literature on adolescent brain development

## OREGON STATEWIDE YOUTH REFERRALS AND LANE COUNTY YOUTH REFERRALS 2007 - 2017




is also challenging the age-old dichotomy of child or adult, with adulthood somehow magically occurring at 18 years of age. This binary categorization has detracted from viewing the transition from adolescent to adult as a developmental process that spans the ages of 14 years to the early 20s. In summary, research on adolescent brain development has confirmed that teenagers have less ability than adults to make judgments and decisions regarding risks and future-orientation. Risky behaviors can be immediately rewarding, but have serious negative consequences--and the adolescent brain encourages experimentation and risk-taking--thus setting up teenagers to make poor decisions that can result in their involvement with the juvenile justice system.

### U.S. SUPREME COURT WEIGHS IN

The nation's highest court has affirmed the original premise of the Juvenile Court that recognized the reduced culpability of youth due to their age, and in doing so, has nudged the juvenile justice policy pendulum toward a "smart on crime" approach. Part of those sweeping changes to the Juvenile Court originated from a series of U.S. Supreme Court decisions beginning in the early 1960s. The most significant decisions regarding juveniles and their reduced culpability have happened in the past 20 years. Since 2005, the Court has ruled four times that youth under the age of 18 years of age must be

JUVENILE OFFENDING IS AT THE LOWEST LEVEL IN 60 YEARS

NATIONWIDE THERE WAS A 58% DECREASE IN JUVENILE ARRESTS BETWEEN 2016 AND 2007

IN OREGON THERE WAS A 56% DECREASE BETWEEN 2017 AND 2007

IN LANE COUNTY THERE WAS A 46% DECREASE BETWEEN 2017 AND 2007

sentenced differently than adults, according to the Eighth Amendment (Feld, 2017).

*Roper v. Simmons (2005):* The Court held that it was cruel and unusual punishment to sentence a person to a death sentence if they committed the crime before the age of 18 years. The Court held that youth lack maturity and had an underdeveloped sense of responsibility.

*Graham v Florida (2010):* In a further effort to delineate the differences between youth and adults, the Court ruled that the Eighth Amendment prohibits life without parole sentences for youth who commit crimes other than homicide. The Court emphasized again that children are less culpable than adults because of their underdeveloped brain functions.

*Miller v Alabama (2012):* The Court went one step further in clearly articulating the mitigating factor of age, and held that mandatory life without parole sentences violated the Eighth Amendment ban on cruel and unusual punishment.

*Montgomery v. Louisiana (2016):* In the latest Court ruling that highlights the legal differences between youth and adults, the Court held that Miller v. Alabama applied retroactively, and that youth could only be sentenced to life without parole only under the rarest of cases when the crimes reflect irreparable corruption.

These U.S. Supreme Court decisions have trickled down to the states, and they have implemented the Court's decisions in a checkerboard, non-uniform manner. For example in 2017, as a result of U.S. Supreme Court decisions, New York and North Carolina passed laws that raised the age of juvenile court jurisdiction from 16 years of age to 18 years of age—these were the last remaining states that automatically prosecuted 16 year olds as adults, no matter what the crime was (National Conference of State Legislatures, 2018). In the same year Oregon passed laws that addressed conditions of confinement for juveniles, including a ban on solitary confinement as a form of punishment. In the same year, New Jersey became the fifth state to require lawmakers to consider the racial and ethnic impact of new criminal and juvenile justice policies.

## LARGE DECREASES IN JUVENILE CRIME

The legal changes to the juvenile justice system brought on by U.S. Supreme Court decisions were significant, and at the same time a larger contextual factor was at play: the rates of juvenile crime across the nation plummeted since the mid-1990s. Juvenile offending nationwide is at its lowest point in 60 years. In 2016 (the most recent data available), there were an estimated 856,130 youth arrested nationwide by law enforcement, a 58% decrease since 2007 (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2018).

In Oregon, the juvenile offending rates followed the national trends. In 2007 statewide there were 26,189 youth responsible for 40,961 referrals (1.6 referrals per youth) to county juvenile departments. In 2017, there were 11,699 youth responsible for 18,144 referrals (1.6 referrals per youth) to county juvenile departments, a 56% decrease in referrals (JJIS Reports, 2018).

Lane County Youth Services experienced large decreases during the same time. In 2007 there were 1,944 youth responsible for 2,715 referrals (1.4 referrals per youth). In 2017, 993 youth were responsible for 1,475 referrals (1.5 referrals per youth), a 46% decrease in referrals (JJIS Reports, 2018). Most people applauded these trends although the exact reasons for such dramatic declines in juvenile offending across the nation, in Oregon, and in Lane County remain largely unexplained.

# JUVENILE JUSTICE PENDULUM


## HISTORY OF LANE COUNTY JUVENILE JUSTICE

It is important to understand the development of Lane County's juvenile court system because the historical trajectory (including the policy pendulum swings) has directly impacted the features of the current juvenile court. In many ways, Lane County's juvenile justice system mirrors the consistent cyclical changes in the national juvenile justice landscape.

Prior to 1945, juveniles who committed crimes in Lane County were tried in adult court, and if required, detained with adults in jail. The League of Women Voters was concerned about the situation and conducted a survey to determine the scope of the issue. Their efforts to educate the Eugene/Springfield communities and to advocate for a separate juvenile detention facility helped to bring together various community groups and service clubs around the issue. In 1949, the groups raised $13,000 to acquire a ten-room farmhouse in Springfield to serve as the county's first juvenile detention facility. The building was named after Circuit Court Judge G.F. Skipworth, who was a strong advocate for a separate juvenile justice system (Lane County Youth Services Detention/Phoenix Orientation Manual, October 2009).

For the next several years, Judge Skipworth established a citizen advisory board to oversee the improvements and operation of the facility, and also to begin to sow the seeds of broader community support for a new Juvenile Court building. After a focused and organized education effort, voters approved ballot measures for a new facility which was completed in 1958. This building served the community for many years, until a national moral panic about juvenile crime engulfed the local conversation about how best to serve youth involved in the juvenile justice system (Lane County Youth Services Detention/Phoenix Orientation Manual, October 2009).

IN 1996 LANE COUNTY VOTERS APPROVED $39 MILLION BOND MEASURE FOR NEW JUVENILE JUSTICE CAMPUS AT THE HEIGHT OF THE SUPER-PREDATOR MYTH

## THE "SUPER PREDATOR" MYTH

Prior to the 1990s several national issues had a direct effect on shaping the juvenile justice system in Lane County. In 1971 President Nixon declared a "war on drugs," which set in motion national efforts to increase drug enforcement and increase sentence lengths, and establish mandatory minimum sentences for many drug crimes.

In the early 1990s, adult and juvenile crime was quickly increasing to historic levels, including an increase in juvenile violent crimes. Seizing the moment with a series of poorly substantiated papers, political scientist John DiIulio publicly coined the term "super predator" to describe a new breed" of offenders, "kids that have absolutely no respect for human life and no sense of the future. . . .These are stone-cold predators!" (p. 23). DiIulio described these young people as "fatherless, Godless, and jobless" and as "radically impulsive, brutally remorseless youngsters, including ever more teenage boys, who murder, assault, rob, burglarize, deal deadly drugs, join gun-toting gangs, and create serious [linked] disorders" (Bennett, DiIulio, & Walters, 1996, p. 27). The media was quickly dominated with stories depicting mostly inner-city, poor, youth of color, who became the faces of the "super predators."

During the moral panic about super-predators, many states, including Oregon passed mandatory minimum sentencing laws in attempts to crack down on crime. In 1994, voters in Oregon passed Measure 11 that imposed mandatory minimum sentences for 16 violent crimes, and provided for mandatory waiver to adult court for youth ages 15 – 18 years old, meaning youth as young as 15 years old could be tried as an adult under Measure 11. In 1996 on the heels of Measure 11, Lane County voters approved a $39 million dollar bond measure for the construction


Lane County Juvenile Justice Center in Eugene, Oregon

of a new Juvenile Justice Center that contained a 96 bed detention facility, two juvenile court rooms, office space for staff and juvenile counselors, an expanded drug and alcohol residential program, and a 20 bed residential secure shelter program. The juvenile justice policy pendulum had swung decidedly towards "Tough on Crime."

## THE JUVENILE JUSTICE POLICY PENDULUM AFTER 1996

DiIulio's dire predictions of increasing juvenile crime fueled by a new breed of "super-predators" did not happen. Shortly after his proclamation, DiIulio recanted his position and admitted he had misinterpreted the data. About the same time, juvenile crime rates peaked, and have steadily decreased every year since then. But the effects of the "Tough on Crime" era were enduring on communities across the nation , including Lane County, that now had a large 96-bed detention facility with not enough youth referrals to fill the beds, nor an operating budget to fully staff the facility.

By now, the national juvenile justice policy pendulum had started to swing back towards a "Smart on Crime" approach that included a recognition of the developmental process of juvenile delinquency, the effects of early childhood trauma on brain development and subsequent juvenile criminality, the effects of family functioning, mental health, drug and alcohol abuse, the effects of negative and antisocial peers, the effects of school failure, and the disproportionate minority contact that snared many youth of color into the juvenile justice system. The original tenets of the juvenile justice system recognizing youth as something different than little adults, was finally emerging again after decades of tough on crime policies.

## TOWARDS SMART ON CRIME

The national conversation regarding juvenile crime was increasingly influenced from the emerging bio neurological and social science research that indicated that adolescents were different than adults in three important ways that affected their behavior, and therefore their likelihood of becoming involved in the juvenile justice system. One was the fact that youth have less capacity for self-regulation compared with adults, especially in emotionally charged situations. Another important difference was that youth are more susceptible to negative peer influences and immediate incentives compared with adults. Finally, youth were found to be significantly less future-oriented than adults and less likely to make decisions based on future consequences. The combination of these factors helped explain why youth were far more likely than adults to engage in high risk behaviors that had immediate rewards, but harmful consequences (National Research Council, 2013).

## ORIGINS OF THE PHOENIX TREATMENT PROGRAM

The national conversation about how to reform the juvenile justice system to better meet the needs of youth, informed the beginnings of Lane County's Phoenix Treatment program. Soon after the new Lane County Juvenile Justice complex opened in 2000, discussions began on how to better serve the needs of youth and the community while at the same time adhering to the emergent trends in best practices for juvenile justice. An unmet need was identified--to provide treatment services for youth who would otherwise be sent to placements outside of Lane County. Specifically, there was a need for services for medium to high risk youth who were on formal court probation, and who had demonstrated they were unable to live in the community. These youth were at high risk of reoffending, and had sometimes failed a less restrictive treatment program, but they were not such a high risk to community safety to warrant detention.

## RISKS, NEEDS, AND RESPONSIVITY MODEL

At the same time, research was indicating that best practices in juvenile justice were clustered around five concepts (Cullen, 2013; Landenberger & Lipsey, 2005):

*Risk:* Services should be targeted to higher risk youth

*Need:* Services should target criminogenic risk/need factors, including antisocial attitudes and beliefs, antisocial peers, low family functioning, academic failure, and impulsivity/lack of control

*Treatment:* Services should provide structured learning approaches, cognitive behavioral approaches, and family therapy

*Responsivity:* Services should address barriers to treatment

such as lack of motivation, anxiety, reading levels, and should incorporate individual characteristics such as age, gender, gender expression, race, and culture

*Fidelity:* Treatment should be implemented as designed and planned

## JUDGE LEONARD LEADS THE WAY

Judge Kip Leonard led efforts to create a new program and he worked closely with Juvenile Counselors, administrators, researchers and practitioners to look for innovative programs and practices that echoed his strong conviction that "you can't punish a kid into success" (Kip Leonard, personal communication, July 27, 2018). As a result, the Phoenix Program started in 2005, with the guidance from Center for Family Development psychologist Mitch Schwartz, who also advocated for a strength-based therapeutic program focused on helping youth be successful in the community (Mitch Schwartz personal communication, October 15, 2018). The original program was co-ed and was designed to be six to nine months in duration.

## THE PHOENIX TREATMENT PROGRAM: A STRENGTH-BASED APPROACH

The Phoenix Treatment Program approach was a "strength-based, family-focused, cognitive-behavioral skill-building program that integrates components of several evidence-based models, including Motivational Interviewing, Multi-systemic Therapy, and Cognitive Behavioral Therapy" (Lane County Youth Services Phoenix Treatment Program Parent Orientation Handbook, n.d.).

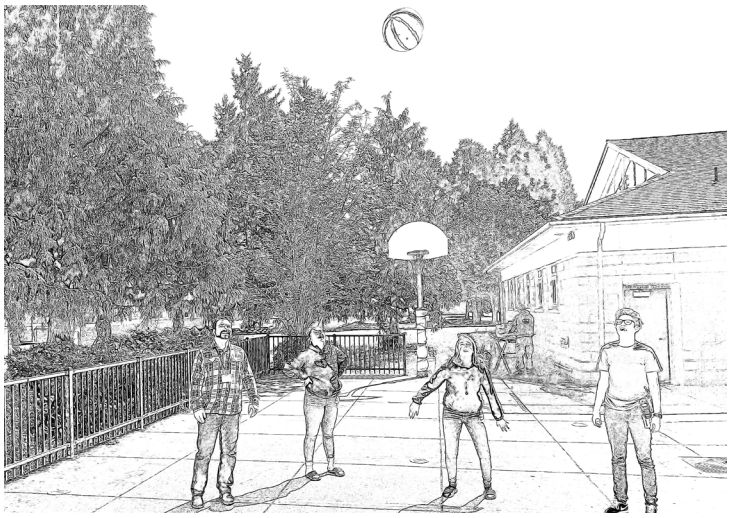
The program was originally designed to address cognitive distortions as the primary treatment need, and was not designed to work with youth with other types of mental illnesses. Although the Phoenix Treatment Program addressed drug and alcohol issues, it was not the program's primary focus. In summary, the program was designed to work with youth where the primary diagnosis was a behavioral or emotional disorder (Lane County Youth Services Orientation Manual, 2009)

The goal of the program was to reunite youth with their families in the community, and sought to achieve this goal with a comprehensive individual, family, and group therapy components. Behavior management was enforced with a token economy system that utilized a point/level system that rewarded positive behaviors. Progress in the program was in large part determined by successful advancement through the levels that corresponded to increased skills. In addition, youth were required to attend academic classes located in the secure facility, and to participate in groups that addressed social skills, anger management skills, and problem solving. These components were considered to be best practices for residential treatment for youth with emotional and behavioral disorders (McCurdy & McIntyre, 2004). These original theoretical underpinnings remain in place today.

## LOCATED IN SECURE POD

Soon after the new 96-bed detention facility was completed, it became increasingly suspected that the beds would never be filled completely. One reason was budgetary--there were no operating funds to fully staff the facility. The other reason was the plummeting youth crime rate in Lane County. As the Phoenix Treatment Program looked for a suitable space in which to operate, the logical conclusion was to house it in one of the secure detention units.

The 24-hour/365 day program was housed in the



The Phoenix Treatment Program moved to a non-secure Residential Treatment setting in Junly 2017

secure portion of the building and shared half of a pod with Detention. Each pod contained 16 beds and was physically separated by a common "control" area. It was not uncommon for staff to share time between Detention and Phoenix as needed to cover breaks or as conditions warranted from time to time during shifts. Although the Phoenix Program was (and still is) primarily a cognitive behavioral treatment program, it was housed in the secure unit with all the trappings of a jail. In this way, it was a microcosm of the national debate that centered on the dichotomy of "tough on crime" and "smart on crime." On one hand, the Phoenix Program was attempting to be "smart on crime" by addressing youth behavioral and emotional needs from a research-based perspective, and on the other hand, the it was housed in a secure unit with locked doors and restricted movement that looked and felt a lot like "tough on crime."

## CHANGE FROM SECURE TO RESIDENTIAL SETTING

Concerns about the long-term negative effects of juvenile detention began coalescing in the national conversation beginning in the early 1990s. There were several threads of research evidence suggesting that youth who were placed in locked detention centers were at much higher risk for negative life outcomes, including continued involvement in the adult criminal justice system (Holman & Zeidenberg, 2007). The Annie E. Casey Foundation (AEC) launched its Juvenile Detention Alternatives Initiative (JDAI) in the early 1990s and established test site locations throughout the country, including Multnomah County, Oregon. The research, training and technical assistance given by AEC provided practical guidelines for reducing detention across the nation, and many juvenile jurisdictions started reforming their detention policies accordingly (Annie E. Casey

Foundation, 2018).

Although the Phoenix Treatment Program was not technically a detention program per se, there were concerns and questions about possible unintended negative consequences resulting from implementing a cognitive behavioral program from within a secure facility that shared physical space and staff with the detention facility. Lane County Youth Services administrators and supervisors were concerned that the likely negative effects of incarcerating youth for months in the secure facility could be outweighing the likely positive effects of the cognitive behavioral interventions. In early 2017, the decision was made to move the Phoenix Treatment Program out of the secure pod and into a residential setting. On July 21, 2017, the program was relocated to a building located on the Lane County juvenile justice campus, where it remains today.

## CONCERNS ABOUT A MIXED GENDER TREATMENT MODEL

There were additional concerns regarding the program being co-ed. National research was documenting the different developmental pathways into the juvenile justice system that girls had compared to boys. For example, girls were found to have higher victimization rates compared to boys, and therefore higher rates of trauma (Chamberlain & Reid, 1994; Anderson & Walerych, 2019). This body of research suggested that girls' trauma history established a different set of needs that male-oriented treatment programs did not address well, and therefore, girls' needs were generally not being met.

Related concerns about mixed gender treatment programs further questioned the appropriateness of male-centered programming and the possible negative effects on girls (Matthews & Hubbard, 2008). In Lane County, as in most other jurisdictions across the country, the number of services for girls was extremely limited, and therefore the Phoenix Treatment Program was one of the few local programs available for girls. In 2013, the Phoenix Treatment Program became a boys-only program for a short time. The program returned to a mixed-gender program shortly thereafter and has remained co-ed since then.

## SUMMARY

The Phoenix Treatment Program is a cognitive-behavioral based residential treatment program for boys and girls ages 12 - 17 years who have an active case with the Juvenile Court. Typically, these youth are on formal probation for a felony or a Class A person-to-person misdemeanor, and are considered to be medium to high risk of reoffending. The program is primarily designed to address the needs of youth with behavioral and emotional disruptions caused by cognitive distortions and to hold youth accountable for their actions. Although the Phoenix Treatment Program addresses some drug and alcohol needs, it is primarily a cognitive behavioral program.

5

# DESCRIPTION OF THE PHOENIX TREATMENT PROGRAM

**THE PHOENIX TREATMENT PROGRAM IS A 16-BED RESIDENTIAL TREATMENT CENTER OPERATED BY LANE COUNTY YOUTH SERVICES FOR LANE COUNTY YOUTH ONLY. THE PROGRAM IS CO-ED AND OFFERS BRS LEVEL 4 SERVICES FOR BOYS AND GIRLS AGES 15 - 17 WHO HAVE AN OPEN CASE WITH THE LANE COUNTY JUVENILE COURT AND WHO HAVE NOT BEEN SUCCESSFUL IN PREVIOUS LESS RESTRICTIVE ENVIRONMENTS. THE PROGRAM USES A STRENGTH-BASED COGNITIVE BEHAVIORAL APPROACH**

## DESCRIPTION OF THE PHOENIX TREATMENT PROGRAM

This section provides contextual information regarding six facets of the Phoenix Treatment Program, specifically the program description, the referral and placement process, the Logic Model for the program, program components, and comparison to other similar programs in the state of Oregon.

*Program Description:* The 16-bed Lane County Phoenix Treatment Program started in 2005 and provides residential treatment to male and female youth ages 12 – 17 years old who are involved in the juvenile court system. Typically, youth are on formal court probation for a Felony or Class A person-to-person misdemeanor, and are considered to be medium to high risk of re-offending (Lane County Youth Services Detention/ Phoenix Orientation Manual, 2009).

The Program is located on the Lane County John Serbu Youth Campus in Eugene, Oregon, and is operated by Lane County as a state of Oregon Behavioral Rehabilitation Services (BRS) Level 4 Residential Treatment Program (State of Oregon Behavioral Rehabilitation Services, n.d.).

Youth referred to the Phoenix Treatment Program by their Juvenile Counselor have generally been unsuccessful in less restrictive settings, and are deemed to be a good match

Aerial view of the Lane County Phoenix Treatment Program location in Eugene, OR

## THE TRIAD OF EVIDENCE BASED PRACTICE:

## COMPONENTS OF REFERRALS TO THE PHOENIX TREATMENT PROGRAM


(Sholonski & Gibbs, 2004)

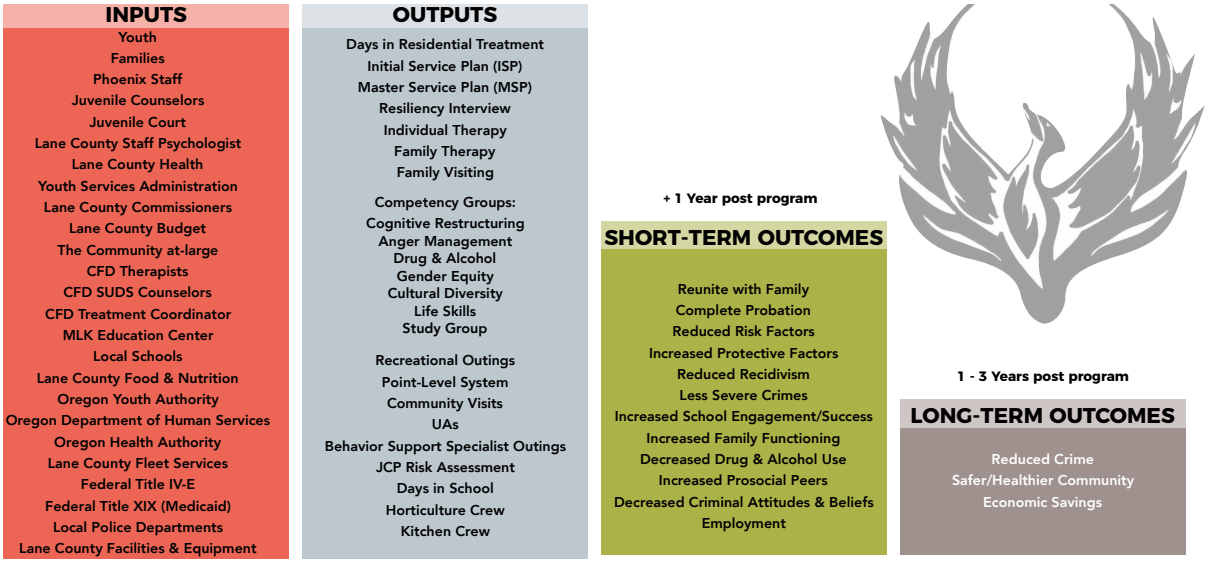
for the Phoenix Treatment Program treatment model of strength-based, family-focused, cognitive-behavioral skill building that integrates components of several evidence-based models including Motivational Interviewing, Multi-Systemic Therapy, and Cognitive Behavioral Therapy (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018). Placement in the Phoenix Treatment Program is voluntary, and youth and their parents/guardians must consent to placement.

*Treatment Structure:* The treatment structure is divided into nine categories: Family Therapy, Individual Therapy, Individual Skill Building, Skill Building Groups, Substance Use Disorders (SUDS) Treatment, School, Mental Health Services, Health Care, and Aftercare Services Therapy (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018). The Center for Family Development (CFD) provides BRS compliant services under the terms of a yearly contract with Lane County that include individual counseling, initial service plan, assessment and evaluation, master service plan (MSP), MSP review, aftercare and transition plan, discharge summary, aftercare summary, and service documentation (Lane County contract #53893, July 31, 2018).

*Group Workers:* Group Workers employed by Lane County Youth Services provide the day-to-day youth supervision, monitoring and behavior management during daily living activities, as well as facilitating Skill Building Groups, and facilitating an incentive-based point-level system. The point-level system incorporates a token economy component and is designed to encourage youth to increase healthy attitudes and behaviors, increase personal accountability, and promote pro social skills (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

## LANE COUNTY PHOENIX TREATMENT PROGRAM

## LOGIC MODEL




*Cognitive Behavioral Approach:* The Phoenix Treatment Program is primarily designed to address cognitive distortions that contribute to delinquent behavior. Although the program addresses mental health and addiction issues, it is primarily a cognitive-behavioral treatment model.

## PROGRAM DURATION

The Phoenix Treatment Program duration has changed over the years, and now it is common that youth spend less than six months (180 days) in the program and are discharged regardless of the degree of completion toward their treatment goals. Since its beginning in 2005, the program average duration has ranged from a low of 81 days to a high of 180 days. In 2018 the average program duration was 103 days.

*Referral Process for Placement in the Phoenix Treatment Program*: The current process for making referrals for placements into the Phoenix Treatment Program is characterized by the Juvenile Counselor (JC) utilizing a number of sources of information and knowledge by which to recommend placement. In general terms, the process is governed by a prevailing attitude amongst the JCs and the Phoenix Treatment Program Supervisor of "Right Kid, Right Time, Right Program" meaning the youth has to be a "good fit" for the program. In this way, the referral process maps nicely onto evidence based practices in which three things are considered: 1. Best available scientific evidence, 2. Practitioner (JC and Phoenix Treatment Program Supervisor) professional expertise, 3. What the client (youth) needs to be successful (Sholonsky & Gibbs, 2004). In practice, when the JC has a youth on their caseload whom they believe would benefit from participating in the Phoenix Treatment Program, they discuss with the Phoenix Treatment Supervisor about a possible placement. Acceptance is based on the following procedure:

*Referrals Screening Process:* The JC completes an updated

JCP Risk Assessment. If the youth scores medium or high risk and is appropriate for out-of-home placement, the JC will discuss with the Phoenix Treatment Program Supervisor. If favorable, the JC will develop a referral packet that contains referral history, JCP Risk Assessment, youth's education, mental health history, information regarding the youth's family functioning, and recommended aftercare plans and placements. The Phoenix Program Supervisor reviews the information and makes a decision to accept the youth within five days.

*Admission Criteria:* A youth must be 12 – 17 years old, function at a cognitive level that will enable the youth to benefit from the program, not have a severe medical condition, and not appear to have issues that would disrupt the current therapeutic milieu in the program

*BRS Authorization:* An Office Assistant is responsible for obtaining the BRS authorization from the parents/ guardians

*Emergency Admissions:* When a JC requests an emergency admission, the Program Supervisor will discuss with the Treatment Coordinator and then notify the JC of their decision (Lane County Youth Services Policies and Procedures Manual update, April 18, 2018)

## THE PHOENIX TREATMENT PROGRAM LOGIC MODEL

Logic models graphically represent how a program works (McDavid, Huse, & Hawthorne, 2013; W.K. Kellogg Foundation Evaluation Handbook, 2004). A "Program" logic model highlights the relationships between program resources (inputs), short term outputs, and longer term outcomes (Knowlton & Phillips, 2013). In this style the program's resources, planned activities, short-term measurable outputs, and longer term outcomes are shown. It should be noted that outputs and the short-term outcomes are easily quantifiable. The long-term outcomes are much more difficult to measure. The underlying logic is that program outputs lead to short-term outcomes that result in long-term outcomes.

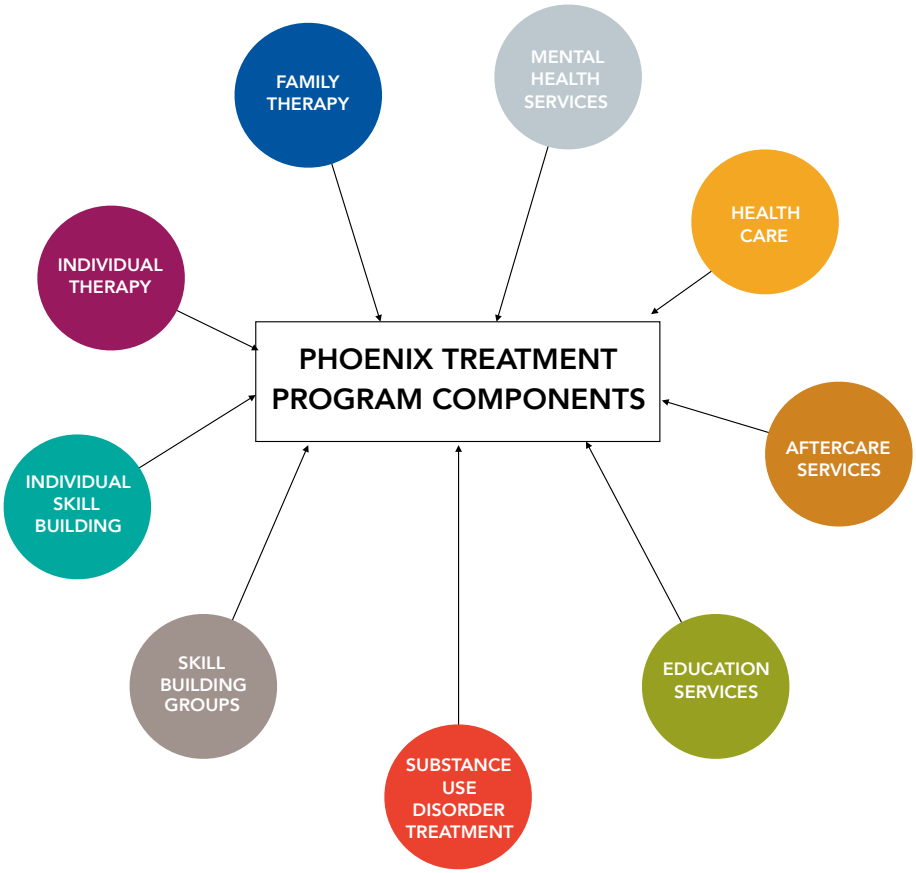
*Phoenix Treatment Program Inputs:* On April 27, 2018, the Evaluator met with the Lane County Youth Services Leadership Team and they described 24 inputs to the Phoenix Treatment Program, encompassing federal, state, county, community, family, and youth inputs.

*Phoenix Treatment Program Outputs:* Outputs are easily quantifiable actions that are related to the activities required to implement the Phoenix Treatment Program. The list of outputs was determined from a variety of sources, including existing program information, interviews with Phoenix Treatment Program staff, and direct observation. A total of 17 program outputs were identified. These outputs were generally the day-to-day activities that the youth experienced as they completed the program.

*Phoenix Treatment Program Short Term Outcomes:* Short term outcomes are the intended results from Outputs (Knowlton & Phillips, 2008) and were assumed to happen in the 12 months immediately following the completion of the Phoenix Treatment Program. Reunification with family is a priority outcome for youth completing the Phoenix Treatment Program. The Phoenix Treatment Program is designed to reduce risk factors associated with criminal behavior and increase protective factors, or strengths that enable youth to desist from criminal behaviors. As such, many of the short term outcomes are measured with the Juvenile Crime Prevention (JCP) risk assessment used by Lane County Youth Services.

*Phoenix Treatment Program Long Term Outcomes:* The long

## PHOENIX TREATMENT PROGRAM COMPONENTS

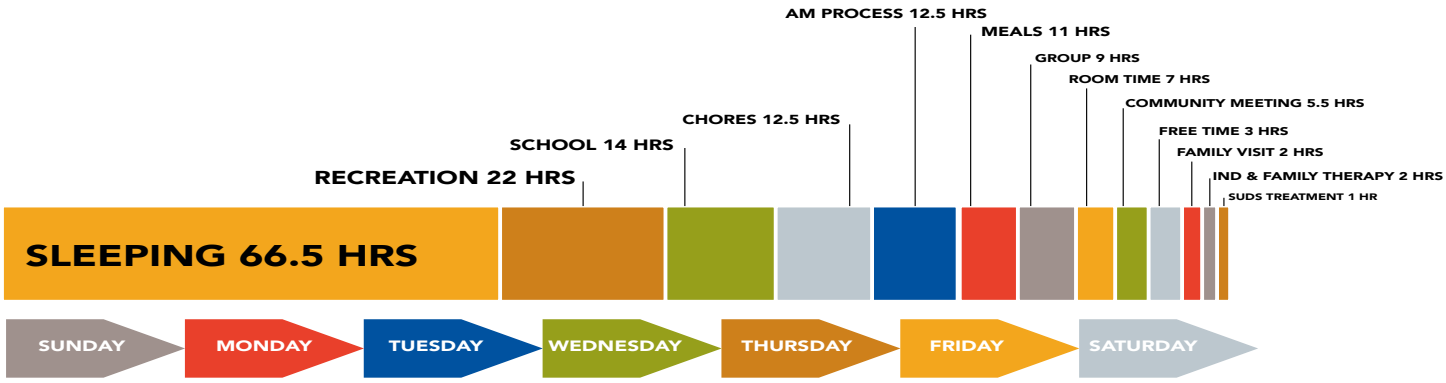



term outcomes for the Phoenix Treatment Program are reduced crime, safer/healthier communities, and economic savings resulting from lower crime (less police required, less court involvement, lower rates of incarceration, lower societal costs stemming from less crime). The outcomes are assumed beginning after one year of youth completing the Phoenix Treatment Program. Long term outcomes were not measured as part of this program evaluation, and it is important to understand why long term outcomes are rarely measured for treatment/intervention programs.

Long term outcomes are the most treasured objective because they can infer causal relationships and therefore establish program effectiveness. But long term outcomes are the most difficult evidence to collect because a longitudinal research design is required in which the same people are examined repeatedly over time. This type of research design is inherently very expensive, and is vulnerable to threats to the study's validity (whether the data is accurate and useful). There is no universally accepted length of a longitudinal study--the number of observations and the length of time varies with research design and objectives (Lewis-Beck, Bryman, Futing Liao, 2004), varying from a few months post treatment to decades after.

The longer duration of observation, the more expensive the data collection is because labor intensive procedures are required to accurately keep track of the people participating in the research. Often there are financial

## PHOENIX TREATMENT PROGRAM ACTIVITIES: TYPICAL WEEKLY HOURS




incentives offered to increase the likelihood that participants will remain in the study, and these also increase costs. Longitudinal studies are also susceptible to validity threats including history, maturation, and mortality. History refers to the multitude of extraneous events that happen to people over time naturally and the effects upon the research study outcomes (extraneous variables, or confounding variables). Maturation refers to the fact that people are constantly changing over time whether they are a part of a longitudinal research study or not, and the changes can affect outcomes (Rubin & Babbe, 2009). Mortality is the metric given to research participants that drop out of, or discontinue their participation in a research study (Rubin & Babbe, 2009). Given the number of challenges associated with longitudinal research, measuring long term outcomes fell outside of the scope of this program evaluation.

How does one place any credence on the assumption that the Phoenix Treatment Program outcomes actually happen, and that the program is effective? This is an important question for Lane County taxpayers who are paying for the program, and for policy-makers and decision makers who are responsible for the program. The answer lies in part with examining existing research on other cognitive behavioral programs for youth involved in the juvenile justice system. Along those lines, a literature review was completed for this program evaluation and a discussion of "what works" is included in the literature review section. The research highlights the theoretical connections between programs and long-term outcomes.

## PHOENIX TREATMENT PROGRAM COMPONENTS

There are nine program services: Family Therapy, Individual Therapy, Individual Skill Building, Skill Building Groups, Substance Use Disorder (SUDS) Treatment, School, Mental Health Services, and Aftercare Services (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Family Therapy:* Each youth is assigned an individual and family therapist from the Center for Family Development. Typically, the individual and family therapist is the same person. Sometimes when there are language barriers, there might be a separate Family Therapist who is bilingual. Family Therapists usually hold family sessions weekly. Most times the family sessions include parents and youth, and sometimes the Family Therapist meets with parents without their youth. In addition to treatment

goal discussions, the family therapy sessions are a time to plan Community Visits (CVs), and to debrief previous CVs (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Individual Therapy:* Each youth receives individual therapy with their assigned CFD therapist, who meets with youth at least once a week. Goals for individual therapy are developed during the initial therapy sessions, and the goals are incorporated into the youth's Master Service Plan (MSP) (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Individual Skill Building:* Each youth is assigned a Primary Group Worker who meets with the youth weekly to work on individual skill building assignments (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Skill Building Groups:* The Skill Building Groups are an integral component to the cognitive behavioral treatment in the program. These groups use evidence-informed curricula (Thinking for a Change, Developing Options to Anger) that address how changes in thinking can change behaviors. The main focus of the Skill Building Groups is to help youth recognize when they are experiencing risky thoughts, feelings, and behaviors, and then replacing them with healthier more prosocial thoughts and behaviors. The intent is that skills are practiced daily, and during CVs (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Substance Use Disorders (SUDS) Treatment:* Juvenile Counselors can refer youth who are in the Phoenix Treatment Program to a SUDS Counselor from CFD. Services include weekly individual counseling, group therapy specific to sobriety, and urinalysis (UA) testing. SUDS Counselors work closely with the Treatment Team to support a youth's sobriety during their time in the Phoenix Treatment Program, and during the 90-day aftercare period. (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

THE PHOENIX TREATMENT PROGRAM IS UNIQUE IN THE STATE OF OREGON: IT IS THE ONLY COUNTY-OPERATED BRS LEVEL 4 RESIDENTIAL TREATMENT CENTER THAT DOES NOT ACCEPT YOUTH FROM OTHER COUNTIES

*School:* Youth attend the Martin Luther King Jr. Education Center (MLK) located on the Lane County Juvenile Justice campus, across the parking lot from the Phoenix Treatment Program. Youth attend school daily from 12:30 to 3:30 except during holidays and school breaks. Youth earn transferrable credits in math, social studies, language arts, and vocational studies. MLK teachers assess each youth and assign school materials that are matched to the youth's skill level. Class sizes are small and teachers are trained in strength-based pedagogy for youth displaying volatile emotions and behaviors. School is included in the point-level system and assign points based on school behavior (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Mental Health Services:* Youth receive a mental health assessment and are provided mental health services as needed, including medication to address mood disorders, impulsivity, and hyperactivity. Parents are always included in decisions to stop/start/change medications for mental health issues (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Health Care:* Youth health care needs are addressed by a

variety of ways. During working hours, a Lane County nurse and physician attend to the needs of the youth. The medical staff is on-call after hours and on weekends. Youth can see their own health care professionals as well (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

*Aftercare Services:* The Phoenix Treatment Program provides 90 days of aftercare to help youth successfully transition back into their homes and communities. An aftercare transition plan is developed for each youth that usually includes individual and family therapy, alcohol and drug treatment services with regular urinalyses (UAs) (Lane County Phoenix Treatment Program Parent Orientation Handbook, 2018).

## DAILY SCHEDULE

The daily schedule is tightly coordinated beginning at 7:00 AM wake-up until 9:30 lights out, and generally follows a prescribed plan. Since the Phoenix Treatment Program is a 24/7 residential program, most of the youths' time is spent sleeping (66.5 hours, 40%), meals (11 hours, 7%), and completing chores (cleaning) (12.5 hours, 7%). For the remainder of the time youths are engaged in activities that are strongly associated with cognitive behavioral treatment. Recreation time is included in this category because youth are able to practice skills they have learned in a more natural setting than individual or group therapy sessions.

- Recreation (22 hours, 13%)
- School (14 hours, 8%)
- AM Process (12.5 hours, 7%)
- Groups (9 hours, 5%)
- Room Time (7 hours, 4%)
- Community Meeting (5.5 hours, 4%)
- Free Time (3 hours, 2%)
- Family visiting (2 hours, 1%)
- Therapy (2 hours, 1%)
- SUDS (1 hour, <1%)

## COMPARISONS WITH OTHER PROGRAMS

It is important to identify the statewide context of residential treatment programs for juvenile justice involved youth in order to make comparisons with Lane County's Phoenix Treatment Program. The following sources were utilized to help identify similar residential treatment programs: discussions with Lane County Juvenile Court Counselors, a selected number of interviews with Oregon Juvenile Department Directors, and web based searches.

The results of these search efforts revealed the Phoenix Treatment program is unique in the state of Oregon in that it is the only BRS Level IV program that is administered by a county juvenile department and does not accept youth from other counties. There are two other county administered BRS IV programs that provide services for their local juvenile justice involved youth and also accept Oregon Youth Authority referrals for youth from other counties—Josephine County's Turning Point

THERE ARE ONLY TWO CO-ED BRS-IV RESIDENTIAL TREATMENT PROGRAMS IN OREGON:

LANE COUNTY'S PHOENIX TREATMENT PROGRAM AND JOSEPHINE COUNTY'S TURNING POINT PROGRAM

## TABLE 3: OREGON BRS IV RESIDENTIAL TREATMENT PROGRAMS

| Contact Agency | OYA Referrals from other counties? | program name | Number of Beds | Ages served | Genders served | location | unique behavioral characteristics |
|---|---|---|---|---|---|---|---|
| Lane County | No | Phoenix Treatment Program | 16 | 12 - 17 | Coed | Eugene | Low to Medium Risk<br>No PSB youth |
| Josephine County | Yes | Turning Point | 12 | 12 - 17 | Coed | Grants Pass | |
| Douglas County | Yes | Touchstone Residential | 8 | 12 - 17 | Boys | Roseburg | |
| Bob Belloni Ranch | Yes | Bob Belloni Ranch | 16 | 13 - 18 | Boys | Coos Bay | PSB youth accepted |
| Catholic Community Services | Yes | Catarino Cavazos Center | 10 | 13 - 19 | Boys | Salem | Targeted population: Hispanic males, gang affected |
| Christian Community Placement Center | Yes | Project 180 | 5 | 12 - 18 | Boys | Salem | Probation Revocation Diversion |
| Eastern Oregon Academy | Yes | | 12 | 12 - 21 | Boys | Burns | |
| Haag Home for Boys | Yes | | 12 | 16 - 25 | Boys | Junction City | PSB Aftercare monitoring |
| Homestead Youth & Family Services | Yes | Homestead | 13 | 12 - 17 | Boys | Pendleton | |
| J Bar J Youth Services | Yes | Boys Ranch | 24 | 13 - 19 | Boys | Bend | PSB youth accepted |
| Janus Youth Programs | Yes | Cordero | 13 | 14 - 19 | Boys | Tigard | PSB youth only |
| Klamath Youth Inspiration Program | Yes | YIP | 9 | 12 - 18 | Girls | Klamath Falls | Parole Revocation Diversion |
| Looking Glass | Yes | Pathways Girls | 8 - 12 | 15+ | Girls | Eugene | Co-occurring disorders: MH/ATOD |
| Looking Glass | Yes | Pathways Boys | 7 - 8 | 13 - 17 | Boys | Eugene | ATOD |
| Looking Glass | Yes | Stepping Stone | 15 | 12 - 18 | Boys | Eugene | PSB youth accepted |
| Looking Glass | Yes | PRD: Parole Revocation Program | 7 - 8 | 12 - 15 | Boys | Eugene | Parole/probation Revocation Diversion |
| NORCOR TOOLS Program | Yes | | 16 | 12 -25 | Boys | The Dalles | Parole/probation Revocation Diversion |
| Parrott Creek | Yes | | 19 | 14 - 18 | Boys | Oregon City | PSB youth accepted |
| Salvation Army White Shield | Yes | Parenting | 6 | 12 - 18 | Girls | Portland | Pregnant & Parenting |
| Salvation Army White Shield | Yes | Wildflowers | 5 | 12 - 18 | Girls | Portland | Commercially Sexually Exploited Children (CSEC) |
| St. Mary's Home for Boys | Yes | | 24 | 10 - 17 | Boys | Beaverton | PSB youth accepted |
| St. Mary's Home for Boys | Yes | | 10 | 12 - 17 | Boys | Beaverton | Specialized Behavioral Interventions |
| Youth Guidance Association | Yes | Son Village | 16 | 12 -18 | Boys | Welches | 2 Transition beds, PSB youth accepted |
| Youth Guidance Association | Yes | Charis Ridge | 9 | 12 - 18 | Boys | Troutdale | PSB youth accepted |
| Youth Progress Association | Yes | Smith House | 9 | 16 -25 | Boys | Portland | PSB youth accepted |
| Youth Progress Association | Yes | Jordan House | 7 | 16 - 25 | Boys | Portland | PSB youth accepted |

Residential Program and Douglas County's Touchstone Program. In addition, there are 24 state-wide programs operated by state approved contractors that provide BRS IV services to youth involved in the juvenile justice system (ages 12 – 17). Lane County's Phoenix Program and Josephine County's Turning Point Program are the only two coed BRS IV programs in the state of Oregon. The other 25 BRS IV programs are gender specific. Of the gender specific programs, 20 programs are for boys, with 252 beds available; five programs are for girls, with 36 beds available.

## PHOENIX TREATMENT PROGRAM POINT-LEVEL SYSTEM

The Phoenix Treatment Program uses a point-level system to encourage positive behaviors and advancement through the program curricula. There are two level systems in place to help track progress in the program: the Club Level System (CLS) and the Program Level System (PLS). The CLS is a daily process in which youth earn points towards a five level "club" system that is associated with privileges. Higher club levels allow the youth more privileges. The PLS is a longer four-stage process designed to help youth acquire skills that are required for success outside of the program, and to complete their treatment goals. The PLS is tied into the CLS in that youth must earn a certain amount of daily points as part of their advancement through the Program Level System.

## METHOD

The evaluator reviewed existing documents regarding the point-level system to collect data on the characteristics and functionality of the system. The evaluator also interviewed Group Workers and Program Directors to gain additional insight on the nuances of how the point-level system is administered on a daily basis. In addition, the evaluator collected qualitative data through direct observation of the administration of the point-level system in real time in the Phoenix Treatment Program.

## RESULTS

Club Level System: The CLS is a "today = tomorrow" point system, meaning the points earned today determine the club level for tomorrow. Youth receive scores during 10 time periods in the day, including when the youth is attending the Martin Luther King, Jr. Education Center. During each time period, youth can earn zero to three points in six specific areas, for a total of 18 points per time period. The six areas in which youth earn points are: Limits (following Phoenix Treatment Program rules), Adult Interactions, Peer Interactions, and three individualized treatment goals. There are typically nine different treatment goals that can be included in a youth's treatment plan: Cultivate pro-social peer groups, Cultivate pro-social attitudes and beliefs, Increase skills to avoid substances, Increase thinking before acting, Reduce aggression, Increase ability to make safe choices, Increase academic success, Increase empathy for others, and Respect personal boundaries of others. Phoenix Treatment Program staff score the youth according to this scale:

0 = Poor behavior

1 = Meets some expectations

2 = Meets most expectations

3 = Exceeds expectations

The Club Levels are determined by the average points a youth earns during the 24-hour day. There are four club levels as well as a "No Club" level. The scoring criteria for the club levels are:

THE PHOENIX TREATMENT PROGRAM USES A HYBRID POINT-LEVEL SYSTEM THAT HAS THREE PARTS:

*DAILY POINT SYSTEM WITH CLUB LEVELS

*TOKEN ECONOMY

*PROGRAM LEVELS

| | |
|---|---|
| Platinum Club | Must earn 80% of points or higher |
| Gold Club | Must earn 73% - 79.9% of points |
| Silver Club | Must earn 66% - 72.9% of points |
| Bronze Club | Must earn 60% - 65.9% of points |
| No Club | Earn less than 60% of points |

At various times in the program's history, sometimes signs indicating the youth's club level were attached to the youth's bedroom doors to serve as a reminder of their particular club level.

There are three different types of "time-outs" in the CLS: Level Time Out (LTO), Minor Time Out (MTO), and Personal Time Out (PTO). Phoenix Treatment Program Group Workers can assign LTOs and MTOs to a youth based on the youth's behavior, and typically the Group Worker communicates the reasons why the youth is being assigned a LTO or MTO and the actions required by the youth to successfully complete the sanction. Advancement to the next club level is not allowed until the youth completes the requirements set forth by the Group Worker. Youth on LTOs are sometimes not allowed to go on community visits with their families—decisions are made on a case-by-case basis. Youth can assign themselves a PTO, and are encouraged to do so if the youth is feeling stressed or anxious about a particular situation happening in the moment. All LTOs result in an Incident Report (IR) that is filed electronically on JJIS by the Group Worker who assigned the sanction. Examples of incidents that trigger an LTO are: Assault on staff, Assault on other youth, Threat towards staff, Threat towards another youth, Unauthorized Departure from a Court Ordered Treatment Program (UDCP), Alcohol/Drug use, Property destruction, Ongoing non-compliance, Self-harm, Threat of self-harm, Contraband, Youth misconduct, School misconduct, Sexual behavior, and Boundary violation.

## A TOKEN ECONOMY

The CLS also has a token economy component. Token economies are commonly used in conjunction with point-level systems because it is believed that providing tangible rewards that are earned with good behavior will encourage long-term and sustainable positive behaviors. In the CLS, youth can "purchase" or "rent" items from the "Fun Shack" using "Bonus Bucks" points they have earned and with being on certain club levels. Youth can earn one Bonus Buck every time they earn a "3" on one of their treatment goals. Additional Bonus Bucks are earned by being on Platinum Club level. Items available include personal

THREE LEVELS OF "TIME-OUTS" THAT CAN AFFECT POINTS:

LEVEL TIME OUT (LTO)

MINOR TIME OUT (MTO)

PERSONAL TIME OUT (PTO)

## PHOENIX TREATMENT PROGRAM LEVEL DESCRIPTIONS


Note: As youth complete required work in each level, they can advance to the next program level. The program levels were originally designed to take about six months to successfully complete all four levels

grooming item, snacks and candy, fidget toys, and art supplies. Youth can "rent" items to use for a limited time such as DVD players and radio head-sets.

The CLS is also associated with privileges—higher club levels are associated with increased privileges such as access to the Fun Shack, free "rentals" of electronic items, phone calls (once per day), working in the kitchen, community outings, allowed to be outside of staff sight/sound supervision, and the use of the basketball court without staff supervision.

## PROGRAM LEVEL SYSTEM

*Program Level System:* The PLS is a four stage process in which youth advance as they complete required activities and continue to earn daily points in the CLS. The four stages of the PLS are: Orientation, Commitment, Responsibility, and Integrity. The four stages are progressive and consecutive, in that they build upon the previous level. Youth must advance sequentially through the PLS—that is, it is not possible for youth to skip a level. All youth begin the Phoenix Treatment Program on Orientation. The PLS is designed to be completed in four to six months, depending on how quickly the youth completes their required activities that include understanding of program concepts, assessments, paper and pencil homework packets, participation in groups, participation in school, and participation in treatment.

There is a fair amount of homework included in each program level. For example, the Orientation packet contains 42 pages, the Commitment packet contains 60 pages, the Responsibility packet contains 74 pages, and the Integrity packet contains 42 pages. A substantial portion of each packet is homework that is required to be completed in order to advance to the next program level.

## VISUAL REMINDERS

As a visual reminder of each program level, placards are sometimes placed on the youth's bedroom doors to help

them remember the goals of their particular level and also to serve as motivation for youth who are working to advance to the next level—the idea being there is a certain amount of prestige and confidence gained as progress is publically displayed.

The PLS door placards are:

*Orientation:* "Increase your self-awareness and skills to make successful choices for your life. You commit yourself to working consistently toward your goals even when you encounter roadblocks and setbacks."

*Commitment:* "Increase your self-awareness and skills to make successful choices for your life. You commit yourself to working consistently toward your goals even when you encounter roadblocks and setbacks."

*Responsibility:* "Responsibility level means taking charge of your life and realizing that you are the one that is responsible for the choices and behaviors that have brought you to where you are in life. Are you ready to do whatever it takes to reach your goals?"

*Integrity:* "Integrity is the level when you get ready to transition back to your life in the community. This is the time to make sure that you are being honest and trustworthy with yourself and others. Will you do the right thing even if no one is looking?"

*Group Worker Comments about the Point-Level System:* Group Workers expressed a combination of concerns and tepid approval about the point-level system. The general tenor of the comments were that the Group Workers perceived the point-level system as less-than-ideal because of the amount of time and effort required to administer the system, differences between Group Workers in how points were assigned, tensions with youth who disagreed or did not understand why they received reduced points or sanctions, and concerns that some youth were too focused on the point-level system causing them to lose focus on their treatment goals. There were additional concerns about delayed communications caused by Group Workers completing their shift and not being able to fully communicate their reasoning to the youth until the next day. Several Group Workers were concerned about the appropriateness of the point-level system for youth with significant learning disabilities, giving an example of a youth who had learning disabilities and was not able to successfully advance through the curriculum, but was regularly sanctioned because of lack of progress. Given all the concerns noted, the Group Workers were still marginally supportive of the point-level system because they believed it was a way to manage youth behaviors and to encourage more positive behaviors. Many Group Workers expressed concerns that if the point-level system was eliminated, it would take away a fundamental behavior management technique. There was a palatable desire from the Group Workers to have an effective behavior management system in place, and many expressed a

PROGRESS IN THE PHOENIX TREATMENT PROGRAM IS DETERMINED IN PART BY A YOUTH'S PROGRESSION THROUGH THE PROGRAM LEVELS

GROUP WORKERS PERCEIVED THE POINT-LEVEL SYSTEM AS LESS THAN IDEAL BUT WERE NERVOUS ABOUT ELIMINATING IT ENTIRELY

## TABLE 4: CHART OF PRIVILEGES FOR CLUBS/LEVELS

| | LEVEL TIME OUT | NO CLUB | ORIENTATION | COMMITMENT | RESPONSIBILITY | INTEGRITY |
|---|---|---|---|---|---|---|
| Extra items that you can have in your room (must be approved by staff and put on your inventory) | NA | NA | 10 | 20 | 20 | 20 |
| Posters in room on flip charr paper. All items glued on flip chart and tape on top of flip chart | Yes<br>Up to 4 posters | Yes<br>Up to 4 posters | Yes<br>Up to 4 posters | Yes<br>Up to 4 posters | Yes<br>Up to 4 posters | Yes<br>Up to 4 posters |
| Hygiene items from home | 4 items | 4 items | 4 items | 4 items | 4 items | 4 items |
| Make-up—can have 3 out of 6 of the following items: foundation, lipstick, eye liner, eye shadow, mascara, lip liner. Applicators do not count as items | 3 items | 3 items | 3 items | 3 items | 3 items | 3 items |
| Coloring Book with washable crayons | Yes | Yes | Yes | Yes | Yes | Yes |
| Use of Fun Shack | No | No | Yes-must be on Silver Club | Yes-must be on Silver Club | Yes-must be on Silver Club | Yes-must be on Silver Club |
| Rent Radio Headset | No | No | No | Yes-in room only | NA | NA |
| Radio Headset 24/7 free use | No | No | No | No | Yes-in room only | Yes-in room only |
| DVD Player—free use in room | No | No | No | No | Yes—1 day/week | Yes—2 days/week |
| DVD Player rental | No | No | No | No | Yes | Yes |
| Control of TV Remotes | No | No | No | Yes-must be on Gold or Platinum Club | Yes-must be on Gold or Platinum Club | Yes-must be on Gold or Platinum Club |
| Fun Shack Discount 50% off | No | No | No | No | No | Yes-1st of month |
| Phone calls (one call per day if time avail) | No | No | Yes-15 min | Yes-15 min | Yes-15 min | Yes-15 min |
| Buy a watch (from Fun Shack) | No | No | No | No | Yes | Yes |

willingness to consider changes to the existing point-level system.

## DISCUSSION

The Phoenix Treatment Program utilized a hybrid point-level system combined with a token economy to encourage positive behaviors in the youth who participated in the program. The CLS is a daily accumulation of points that determine a youth's club level the following day. Higher club levels allow the youth more privileges and opportunities to trade some of their points for tangible goods from the Fun Shack. While the youth can't technically lose points during the day, it is possible for Group Workers to sanction the youth for negative behaviors, which prevents the youth from earning additional points until the terms of the sanction have been satisfied. The PLS is a longer-term four stage process that youth must complete in a sequential manner in order to progress through the program and to demonstrate to the juvenile court that they are making positive steps in

THE POINT-LEVEL SYSTEM UTILIZED BY THE PHOENIX TREATMENT PROGRAM DOES NOT ALIGN WITH BEST PRACTICES FOR RESIDENTIAL TREATMENT FOR YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM

meeting their treatment goals.

*Not Best Practices:* The Phoenix Treatment Program point-level system does not align well with what is currently known about best practices in residential treatment settings for emotionally and behaviorally challenged youth. Beginning in the early 2000s, researchers began to question the theoretical foundation of point-level systems and their validity with many populations including juvenile justice involved youth (i.e. Boerke & Reitman, 2011). Since then, the academic literature has described increasing concerns about using point-level systems in juvenile justice settings, including concerns that point-level systems effects are short-lived, they do not encourage acquisition of skills required to live successfully outside the system, they do not encourage individualized treatment, are cognitively and culturally inappropriate, and are are often administered unevenly by front-line staff (Tompkins-Rosenblatt & VanderVen, 2005; Mohr & Pumariega, 2004; VanderVen 2000, 2003, 2009).

Perhaps the most damning criticism of point-level systems and associated token economies is that youth should not have to earn their treatment (VanderVen, 2000). There are additional tensions with the point-level system and the relationship between LTO sanctions and the ability for youth to visit their families. It is logical to consider the community visits as a benefit that must be earned by demonstrating positive behaviors in the program, but this perspective is counter to the Phoenix Treatment Program's original ideology of teaching positive skills that allow youth to live successfully outside of the program. It is possible that the point-level system encourages behaviors that do not necessarily transfer well to the outside community, and that withholding community visits might eliminate the opportunities for youth to practice their new skills in a natural environment. The reader is encouraged to review the section on token economies found in the literature review section of this evaluation for more information.

It is understandable why Group Workers in the Phoenix Treatment Program would be concerned about behavior management because that is a significant portion of their daily work with youth. And, it should be noted that the current point-level system does provide a structure and a framework by which to communicate behavior expectations and to hold youth accountable for their actions in the program, as well as documenting progress in completing treatment goals. That said it is also notable that Group Workers had many concerns about the current point-level system and at the same time expressed an openness to consider changes that are more aligned with positive youth development and strength-based behavioral management practices.

"YOUTH SHOULD NOT HAVE TO EARN THEIR TREATMENT"

VANDERVEN, (2000)

6

# PHOENIX TREATMENT PROGRAM OUTCOMES

**THE PHOENIX TREATMENT PROGRAM SHOWED POSITIVE RESULTS. IN 2017 YOUTH WHO PARTICIPATED IN THE PHOENIX TREATMENT PROGRAM RECIDIVATED NEARLY 8% LESS COMPARED TO SIMILIAR YOUTH WHO DID NOT PARTICIPATE IN THE PHOENIX TREATMENT PROGRAM. QUALITATIVE OUTCOMES INDICATED A HIGH LEVEL OF SATISFACTION WITH THE PROGRAM FROM MANY STAKEHOLDERS INCLUDING YOUTH AND FAMILIES. THE PROGRAM UTILIZATION HAS DECREASED IN RECENT YEARS AND HAS AVERAGED JUST UNDER 60% DURING 2014 - 2018**

## PHOENIX TREATMENT PROGRAM OUTCOMES

This section describes the Phoenix Treatment Program outcomes in two large categories: quantitative outcomes and qualitative outcomes. The quantitative outcomes include an examination of the ages of the youth and their program duration for the years 2005 through 2018, the utilization of the program for the years 2005 through 2018, an examination of the incidents in the program for the years 2014 through 2018, and a comparison of outcomes for youth who participated in the program during 2017 with youth who did not participate in the program during 2017.

The qualitative outcomes include an exploration of the attitudes, perceptions and experiences of two important groups: the youth and families who participated in the Phoenix Treatment Program during 2018, and the Lane County Youth Services staff and contracted treatment providers who worked with the youth and families during 2018.

Program outcomes are important because they indicate whether an intervention or treatment is "working" or not. Traditionally, outcomes for juvenile justice programs have primarily focused on recidivism rates as a measure of community safety, with recidivism being defined as a new criminal referral to a juvenile department. A new criminal referral is usually defined as a police report to a juvenile department that alleges one or more felony or misdemeanor offenses.

*"Public" and "Private" Outcomes:* New referrals can be thought of as "public events" because they are easily observable and represent a single point-in-time event. Policy makers and elected officials have relied on the very public event of recidivism as the singular outcome because it is easy to understand and easy to communicate the results to the tax-paying public who are understandably interested in supporting juvenile justice interventions that result in less crime. There are some concerns with

RECIDIVISM, WHILE AN IMPORTANT MEASURE, IS A DEFICIT-BASED PERSPECTIVE

relying solely on recidivism as an outcome measure that bear discussion. There is a growing recognition that while recidivism is an important outcome variable, it is clearly a negative measure, as well as a rather coarse and incomplete measure of success. With the increasing interest in measuring positive youth development, more attention is being paid to other outcomes that are correlated to what is known about healthy long-term life success. For example, researchers are starting to pay attention to "private events" that mark changes within an individual youth. These private events are developmental and take place over time, and can be related to treatment interventions, although causation is difficult to demonstrate without rigorous scientifically designed research studies such as randomized controlled trials. Nevertheless, these "private events" are recognized as a more positive manner in which to measure youth outcomes, and they map directly onto theories of positive youth development, harm reduction and best practices in juvenile justice interventions. Using a harm reduction perspective encourages measuring "private events" such as reductions in risk, and increases in protective factors as a means to measure positive change.

## JUVENILE CRIME PREVENTION RISK ASSESSMENT

In Oregon, risk and protective factors are measured using the Juvenile Crime Prevention (JCP) Risk Assessment that categorizes risks and protective factors across seven domains: School, Peers, Behavior, Family, Substance Use, Attitudes Values and Beliefs, and Mental Health. A composite risk score with a maximum value of 30 is calculated and youth are categorized into three risk levels: High (14 or more), Medium (6 – 13), and Low (0 – 5). While it is recognized the JCP is not an entirely strength-based measurement tool, it does take into consideration some "private events" that have been shown to be strongly related to positive youth development, such as reductions in overall risk scores over time. These changes over time are known as dynamic risk factors and they are an indication of "private events" that take place within an individual youth that warrant measurement.

Finally, there are other "public events" besides recidivism that are important to examine because they indicate a youth's trajectory after their initial involvement with the juvenile justice system. For example, where a youth resides after their involvement with the juvenile justice system can indicate their developmental progress and it gives some idea about the success of an intervention. The living arrangements after treatment are somewhat of a measure of the youth's progress towards successful outcomes. Ideally, youth are reunited with their families and communities. Sometimes youth are referred to another community-based treatment center. In some cases, youth continue their criminal behaviors and escalate upwards in the system to close custody. All of these possible living arrangements after treatment interventions are at least partial indicators of a program's success.

A STRENGTH-BASED PERSPECTIVE MEASURES POSITIVE GROWTH WITHIN A YOUTH--THESE ARE CALLED "PRIVATE EVENTS"

## PHOENIX TREATMENT PROGRAM QUANTITATIVE OUTCOMES

This portion of the evaluation describes four quantitative analyses. One is an examination of the ages and program duration for the years 2005 through 2018. The second is an analysis of the program utilization for the years 2005 through 2108. The third is an investigation of the incidents recorded in the program during the years 2014 through 2018. The fourth is a comparison of demographics, JCP assessments, recidivism, and living arrangements, between the youth who participated in the Phoenix Treatment Program during 2017 and the youth who did not participate in the Phoenix Treatment Program during 2017. Each quantitative outcomes section is divided into an introduction, methods, results, and discussion.

## AGE OF YOUTH AND DURATION IN THE PHOENIX TREATMENT PROGRAM

This section summarizes the average age of youth and program duration for the years 2005 to 2018. The average age of youth is important because it sheds some light on the possible relationships between age and the appropriateness of the program. Program duration is an important process to examine because it relates to treatment "dosage," which is related to outcomes. The academic literature uses the term "optimal length of stay" to describe program duration, and there is little agreement about what an optimal length of stay really means. Readers are encouraged to review the summary regarding optimal length of stay in the literature review included in this evaluation.

## METHOD

Information contained in Oregon's Juvenile Justice Information System (JJIS) for youth who participated in the Phoenix Treatment Program during the years 2005 through 2018 were exported to Excel spreadsheets. The average age (boys and girls) and the average days spent in the program (boys and girls) were calculated and summarized.

THE TYPICAL YOUTH IN THE PHOENIX TREATMENT PROGRAM WAS MALE, WHITE, 15.6 YEARS OLD, WITH MORE THAN FIVE REFERRALS

(2005 - 2018)

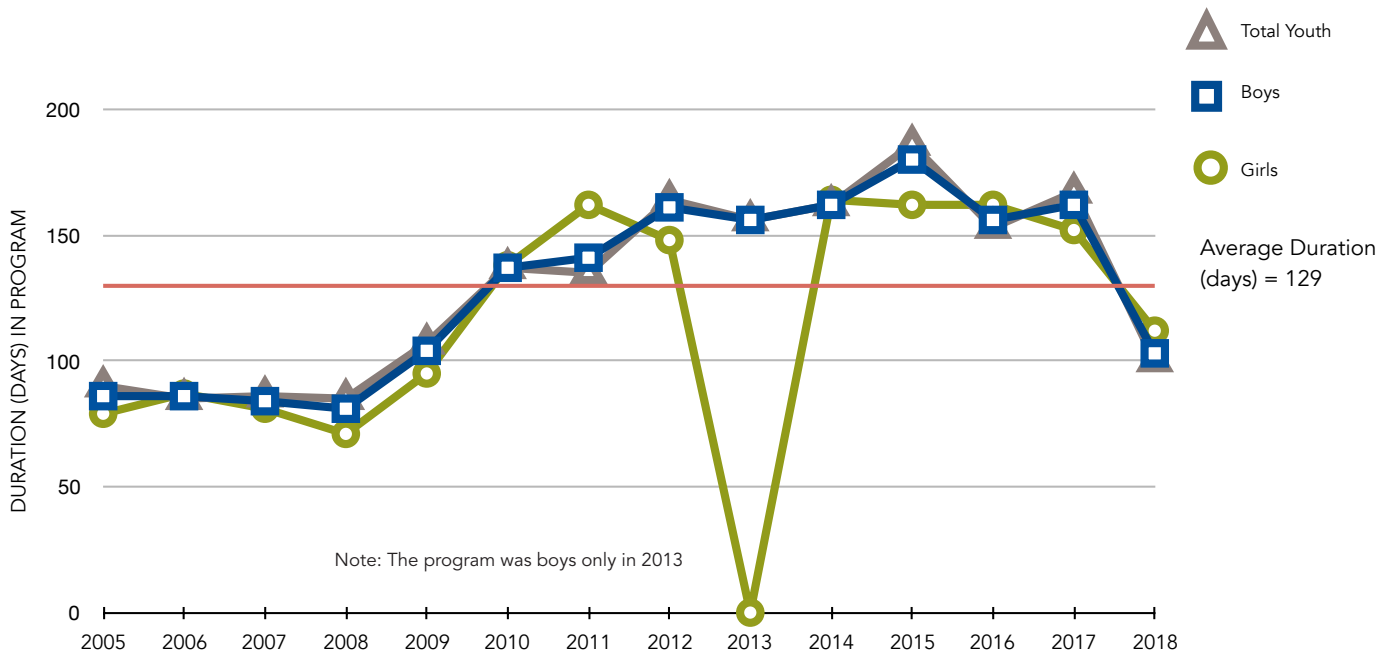
## RESULTS

The average age for youth was 15.6 years old, with boys (15.7 years) being slightly older than girls (15.3 years). The average duration was 129 days, with boys spending slightly more days (130 days) compared to girls (124 days). The average duration ranged from a low of 81 days to a high of 180 days.

## DISCUSSION

The average age for youth who participated in the Phoenix Treatment Program during the years 2005 through 2018 aligns somewhat with the anecdotal evidence from the Juvenile Counselors (JCs). Some of the JCs commented that they considered a youth's age when making referral decisions, and there was a general perception that the Phoenix Treatment Program was not appropriate for younger adolescents (ages 12 – 14 years old). It is not known whether the average age of 15.6 years old reflects a conscious decision making process, or is merely an artifact of the referral process. There is little information in the academic literature regarding the age of juvenile justice

## DURATION (DAYS) IN PHOENIX TREATMENT PROGRAM 2005 - 2018




involved youth who are referred to residential treatment programs.

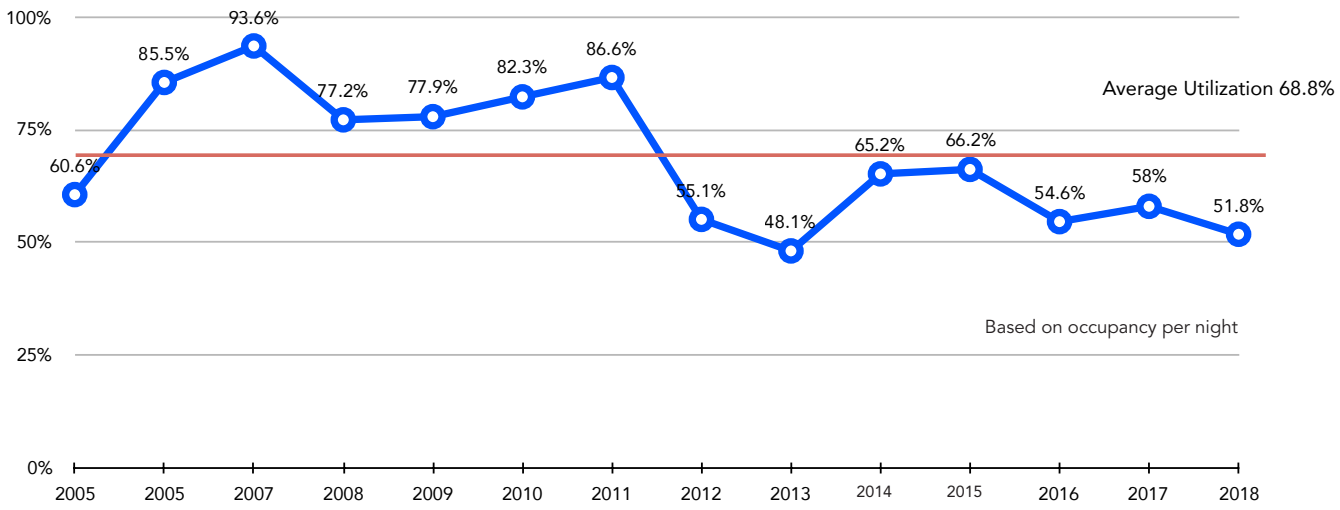
The 129 days (4.3 months) average duration is within the Phoenix Treatment Program's guidelines that are communicated to parents with a youth participating in the program. In the Lane County Youth Services Phoenix Treatment Program Parent Orientation Handbook, it is stated that "most youth that enter the program will stay between 4-5 months" (p.1). There is little information about program duration or optimal length of stay in the academic literature. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) reported that the length of stay for youth in juvenile justice related residential treatment centers ranged from 103 days to 128 days between the years 1997 and 2015 (U.S. Department of Justice, 2018). The 129 days average duration also aligns with the JCs' perceptions that the program is now about a four month program, and that is about the time when most youth exhibit a slowing down in their progress towards their treatment goals. The 129 days average duration did not align with the JCs' perceptions that the program used to be six month duration, and that it has recently shortened its duration. In fact, the program duration was shortest during the first four years after starting (about 84 days during years 2005 – 2008), and there was only one year (2015) when the average duration was 180 days (six months). It is true that the program duration decreased 36% between 2017 and 2018 (from 162 days to 103 days), and it is possible that the JCs' are referring to this recent decrease.

The large range in the average program duration (low 81 days, high 180 days) is worth noting because of its

**129 DAYS**

AVERAGE DURATION IN THE PHOENIX TREATMENT PROGRAM (2005 - 2018)

## PHOENIX TREATMENT PROGRAM UTILIZATION 2005 - 2018




magnitude (more than a doubling of program length) and because of the differences found with other sources of information. The latest Parent Orientation Handbook for the Phoenix Treatment Program indicates the program duration is four to six months (120 days to 180 days), and the data analysis indicated the program average duration was 129 days, just slightly more than the minimum duration mentioned in the handbook.

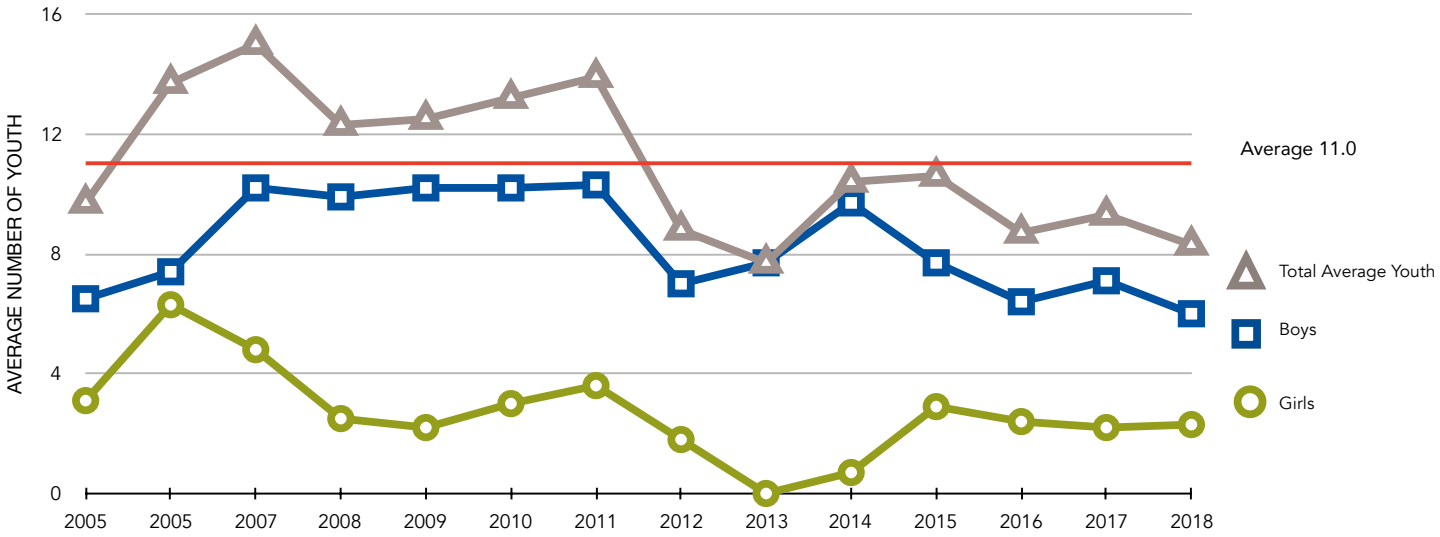
There was little evidence that youth spend near the maximum duration in the program. There were also differences with what the Group Workers and the JCs said about the program duration. For example, some of the Group Workers believed the program duration "sweet spot" was somewhere around four months (120 days), and this aligned well with the quantitative data. The perception that 120 days is about the right duration fits well with the actual average duration of 129 days.

## PHOENIX TREATMENT PROGRAM UTILIZATION

The Phoenix Treatment Program is a 16-bed co-ed BRS IV Residential Treatment Program authorized by the state of Oregon to provide residential treatment services for youth ages 12 – 17 who are involved in the juvenile justice system. The Phoenix Treatment Program accepts referrals from youth under the jurisdiction of the Lane County Juvenile Court, and does not accept referrals from other jurisdictions. Up until mid-2018, only youth who were adjudicated were eligible for referral into the program. Non-adjudicated youth were not eligible for the program. After mid-2018, non-adjudicated delinquent youth were eligible for the program.

The utilization of the Phoenix Treatment Program was examined in context of national, state and Lane County trends in juvenile delinquency cases and referrals to the juvenile court. In the decade between 2005 and 2014 there was a 42% decrease in the number of delinquency cases

## PHOENIX TREATMENT PROGRAM UTILIZATION BY SEX 2005 - 2018




nationwide (OJJDP, 2018). There was a larger decrease in the number of referrals to the juvenile court in Oregon. Between 2007 and 2017, Oregon experienced a 56% decrease in the number of referrals (JJIS Reports, 2018). During the same time period in Lane County's referrals to juvenile court dropped 46% (JJIS Reports, 2018). These large decreases in referrals suggest that fewer youth were "eligible" or "available" for the Phoenix Treatment Program.

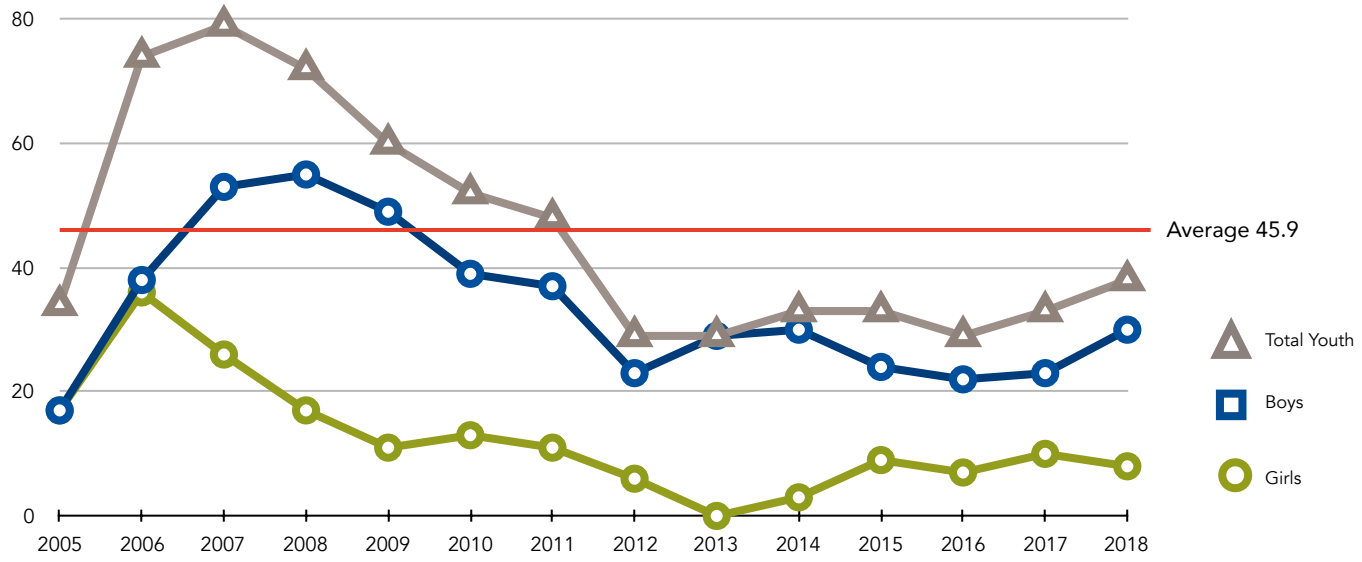
### METHOD

Data in the Oregon Juvenile Justice Information System (JJIS) for the years 2005 – 2018 were exported to Excel. Two analyses were completed. One analysis was a simple frequency count and averages of the number of youth (male and female) who participated in the Phoenix Treatment Program each year, their average age, and the number of days spent in the program. The other analysis was a day-by-day census (male and female) to determine the average number of youth per month and the average utilization per month, based on a 16-bed capacity.

### RESULTS

Between the years 2005 and 2018, 654 youth participated in the Phoenix Treatment Program. Most of the youth were boys (73.3%). The number of youth participating in the Phoenix Treatment Program fluctuated from a high of 79 in 2007, to a low of 29 youth in 2012 and 2013. The average age upon entering the program was 15.6 years old, with boys slightly older (15.7 years old) compared to girls (15.3 years old). Youth spent an average of 129 days in the program, with boys spending 130 days compared to girls spending 124 days. The average number of days ranged from a low of 81 days in 2008, to a high of 180 days in 2015. The average number of youth participating in the program per month was 11.0 (average 8.3 males and 2.7

## PHOENIX TREATMENT PROGRAM TOTAL NUMBER OF YOUTH PER YEAR BY SEX 2005 -2018




females). The average utilization rate varied from a high of 93.6% in 2007, to a low of 48.1% in 2013. The average utilization rate for the years 2005 – 2018 was 68.8%.

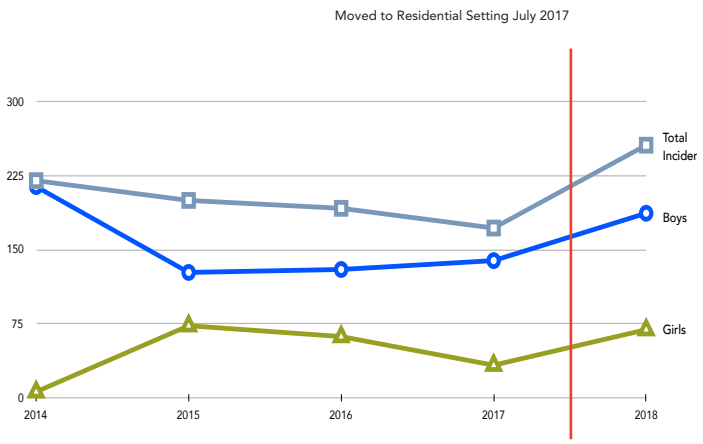
## DISCUSSION

There are several limitations to the utilization analyses that should be noted. One is that the JJIS data could be incomplete or contain errors regarding Phoenix Treatment Program start and stop dates. The other source of error comes from the fact that a small number youth participated more than once during a year. This happened when a youth left the program and then was readmitted. The analysis did not separate out the "repeats."

The quantitative analyses point out several trends and alignment with qualitative data collected in other parts of this evaluation. The average age of youth entering the program (15.6 years old) matches anecdotal evidence collected during the qualitative interviews with the JCs and Phoenix Treatment Program Directors who felt that the program was not well suited for youth ages 12 – 14 because of concerns about a possible lack of emotional maturity and development required to be successful in a residential treatment environment. The JCs and the Program Supervisors also commented that the program was not suitable for older youth, who were nearing their 18th birthday, because of concerns about a lack of engagement from the youth who would likely age-out of their involvement with the juvenile justice system.

The program utilization has fluctuated, with a peak utilization of 93.6% in 2007 and a gradual decreasing trend since then. The average utilization for the most current three years of data was in the 50% range (54.6% in 2016, 58.0% in 2017, and 51.8% in 2018). Part of the explanation for the decrease could be the overall decreases in the number of youth referrals to Lane County

## PHOENIX TREATMENT PROGRAM INCIDENTS 2014 - 2018




Youth Services, thus fewer youth "eligible" for referral to the Phoenix Treatment Program. Another part of the explanation could be concerns about the program effectiveness that were highlighted in some of the qualitative interviews. These concerns about effectiveness could also be partially explained by the observations that the youth and families that come into contact with Lane County Youth Services are more "complex" today than they used to be—meaning there are more examples of youth and families with multiple risk factors and fewer protective factors. These situations manifest themselves as comorbid conditions of severe emotion and behavioral disturbances, trauma history, cognitive development delays, severe mental health needs, and drug and alcohol abuse. It's possible that the Phoenix Treatment Program is perceived by JCs as not being able to adequately meet the needs of the complex youth on their caseloads.

If so, this situation can be categorized as aligning with the underlying philosophy that was strongly voiced by the JCs: "Right Kid, Right Time, Right Program." Perhaps referrals to the Phoenix Treatment Program have decreased over time because the JCs don't think they have the "right kids" at the "right time" for the "right program"—in other words, maybe there are concerns Phoenix Treatment Program is not able to meet the needs of complex youth and families.

## PHOENIX TREATMENT PROGRAM INCIDENTS

This section describes the process that is used to document incidents that occured in the program. Documenting incidents is important for many reasons, including compliance with Oregon law concerning Behavioral Rehabilitation Services programs, capturing information regarding a youth's behavior in the program that the juvenile court considers when making decisions about the youth, and creating a searchable historical data base that can be used to examine trends in incidents over time.

## METHOD

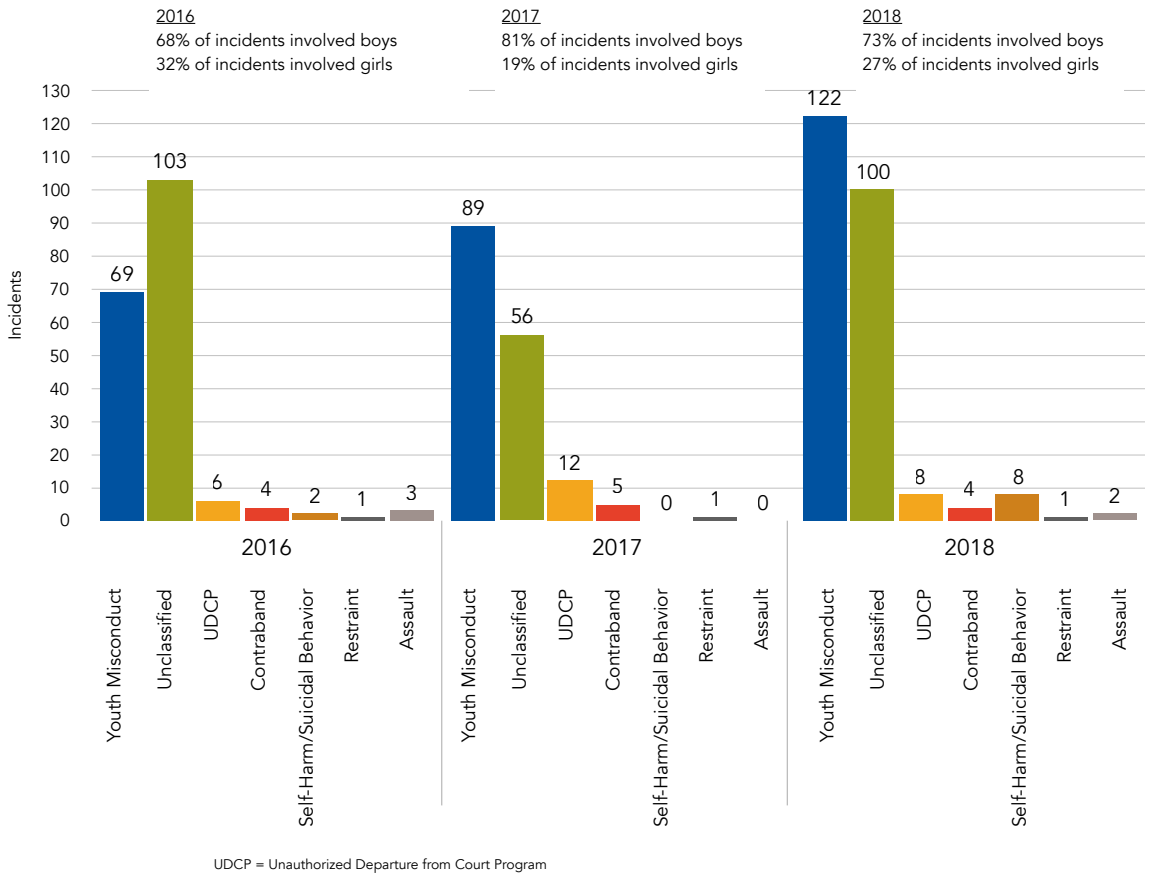
The evaluator reviewed the Oregon Administrative Rules (OAR 410-170-0030(12)(b) BRS Contractor and BRS Provider Requirements for Incident Reports to understand the minimum state requirements for

**1,040** INCIDENTS 2014 - 2018

**5.0** INCIDENTS PER BOY

**1.5** INCIDENTS PER GIRL

## PHOENIX TREATMENT PROGRAM DETAILS OF INCIDENTS 2016 - 2018




UDCP = Unauthorized Departure from Court Program

incident reporting. The evaluator then accessed JJIS for a summary of incidents that occurred in the Phoenix Treatment Program during the years 2014 through 2018. This five year period was chosen because it was a large enough sample to provide insights into incident trends, and it was a manageable amount of data to analyze. The JJIS information was exported to an Excel spreadsheet for analysis. In addition, the evaluator interviewed the Program Supervisors (there was a change in Program Supervisors during the evaluation, therefore two people were interviewed), and several Group Workers to gain understanding about how the incident reporting process was administered. Finally, the evaluator reviewed the BRS Provider Review dated September 10, 2018 that was completed for the Phoenix Treatment Program.

## RESULTS

Oregon Administrative Rules: Oregon Administrative Rules (OAR 410-170-0030(12)(b) BRS Contractor and BRS Provider Requirements for Incident Reports requires that the BRS provider create and maintain a record

of all incidents, including but not limited to incidents described in OAR 413-215-0091(11)(c) which states the BRS provider shall notify the Department (in this case Oregon Youth Authority) within one business day if a critical event occurs, including seclusion or use of physical restraints. A critical event is defined as an event that is likely to cause complaints, generate concerns, or come to the attention of the media, law enforcement agencies, first responders, Child Protective Services, or other regulatory agencies. The BRS Provider Review for the program determined the Phoenix Treatment Program was in compliance with state regulations concerning incident reports.

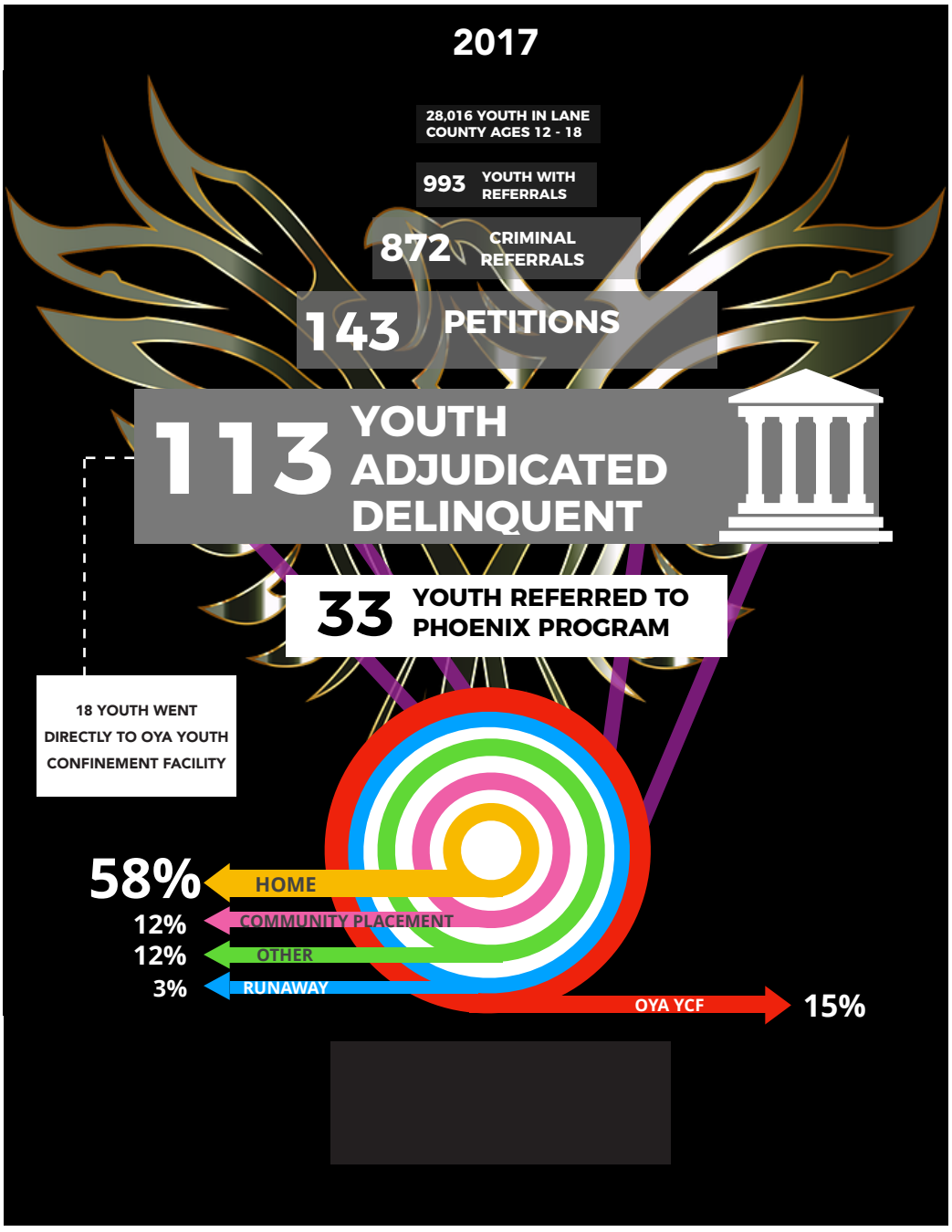
*JJIS Information:* There were 1,040 incidents recorded in the Phoenix Treatment Program for the years 2014 through 2018, ranging from a low of 172 incidents in 2017 to a high of 256 incidents in 2018. There were many different types of incidents that were documented including youth misconduct, escape, contraband, self-harm/suicidal behavior, assault, significant event, informational, medical, and unclassified. The largest incident category was Youth Misconduct (45.7%), followed Unclassified (42.3%), Escape (4.2%), Significant Event (3.6%), Contraband (2.1%), Self-harm/Suicidal Behavior (1.6%). Five incident categories had less than 1% of the total incidents: Assault, Sexual Behavior, Information Only, Peer Fight, and Restraints. There were just three incidents of using physical restraints during the time period, although there was incomplete information for years 2014 and 2015.

During 2014 through 2018 there were a total of 161 youth in the Phoenix Treatment Program and 138 (85.7%) had at least one incident report. Most of the youth in the program were boys (77.0%) and they accounted for 76.5% of the incident reports. Girls accounted for 23% of the youth in the program and were responsible for 23.5% of the incident reports. The average number of incidents per youth was 6.5. A further breakdown by sex showed that boys had an average of 5.0 incidents per youth and girls had an average of 1.5 incidents per youth.

*How Incidents are Recorded:* The process by which incidents are recorded by the Group Workers was straightforward. Group Workers created an incident report whenever a youth's behavior resulted in a "Level Time Out" (LTO) sanction, which included various examples of youth misconduct (i.e. disregarding staff requests, not engaging in group work), contraband, assault and threats to staff and other youth. Other incidents mentioned above also triggered an incident report, such as escape (also known as Unauthorized Departure from a Court Program, or UDCP), self-harm or suicidal behavior, informational, medical and unclassified incidents. Recently, Group Workers have also been generating incident reports for events that cause a "Minor Time Out" (MTO) sanction.

After determining an incident report should be created, the Group Worker entered the data into the JJIS system via a computer terminal located in the secure staff area of the Phoenix Treatment Program. The standardized form was a fill-in-the-field format that included the following information: incident date, date logged, name of Group Worker entering the incident report, status of the report ("locked" or "completed"), completed date, completed by, a summary of the incident with criteria required to remove LTO status if applicable and any follow up instructions, and the category type of the incident (i.e. youth misconduct, significant event). Internal Phoenix Treatment Program policy required incident reports to be "locked" within 24 hours (Monday through Friday). The term "locked" refers to the process by which a Phoenix Treatment Program supervisor (usually the Program

## REFERRAL "FLOW" INTO THE PHOENIX TREATMENT PROGRAM 2017



THE "FLOW" INTO THE PHOENIX TREATMENT PROGRAM WAS VERY NARROW

IN 2017 THERE WERE 95 YOUTH POTENTIALLY "ELIGIBLE" FOR THE PHOENIX TREATMENT PROGRAM.

OF THOSE 95 YOUTH, 33 WERE REFERRED TO THE PROGRAM

Director) reviewed and approved the incident report, and "locking" it to prevent revisions.

## DISCUSSION

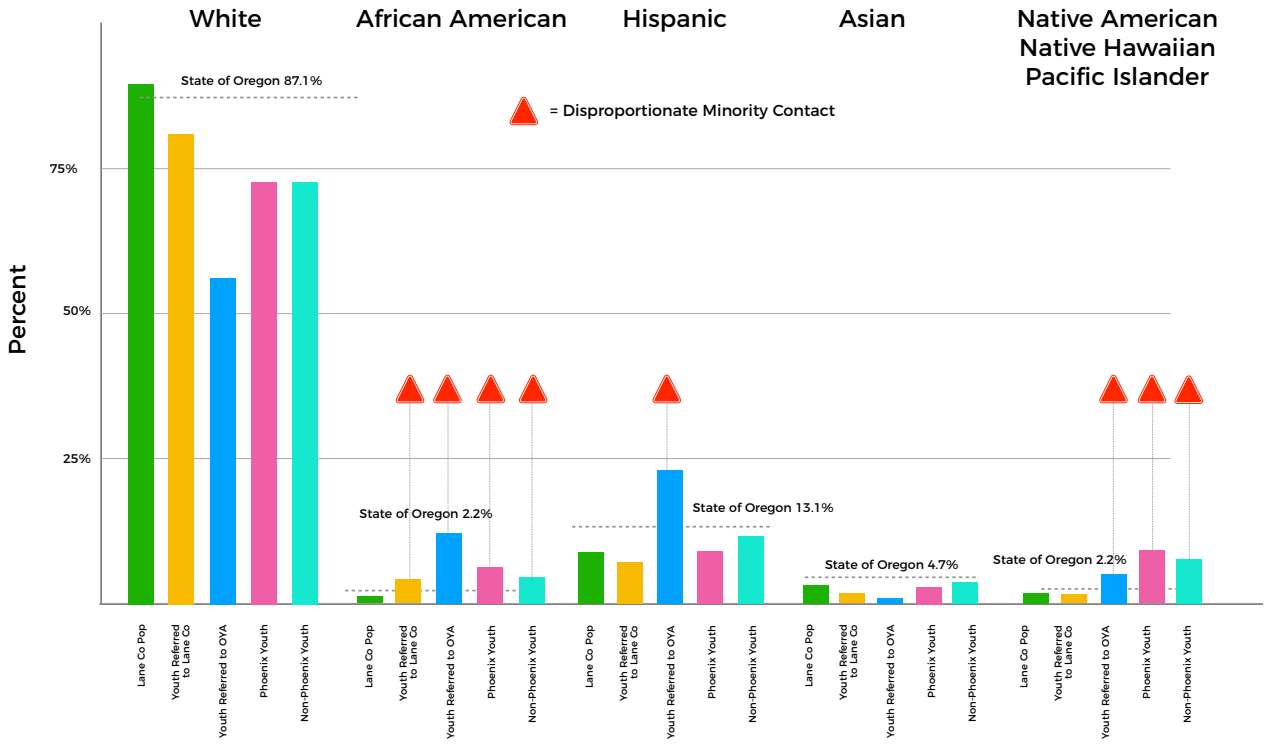
The Oregon Administrative Rules (OARs) provide the reporting requirements for incident reports in the Phoenix Treatment Program, and importantly, the recent BRS Provider Review completed by the state found the program was in compliance with state regulations.

Although the OARs provide some degree of specificity about when and how incident reports should be generated, there are considerable gaps in the reporting requirements especially concerning various lower severity incidents that do not meet the standards in OAR 413-215-0091(11)(c) that pertain to serious events that could garner attention from other agencies or the media. The Phoenix Treatment Program staff used their professional discretion and created internal policies that govern when and how to create incident reports for less severe incidents that impact the treatment milieu and individual youth. Some of these internal policies relate incident reports to the point-level system utilized in the program, for example incident reports were generated for youth behaviors resulting in LTOs and MTOs, both of which are integral components of the point-level system. The incident reports for these types of events also serve as communication tools. For example, in the incident report description, criteria for removal of a sanction were included, as well as follow-up items for JCs and treatment providers. In this way, the incident reports serve as a permanent record that was accessed by several other treatment professionals working with the youth in the program. The incident reports also serve as important documentation that was used by the juvenile court when making decisions about a youth's disposition (outcome of the youth's case). Documenting the number of physical restraints used was also important because a pattern of physical restraints can be an indication of a non-therapeutic environment, and perhaps an unsafe environment for youth and staff. The incident reports also served as possible evidence of new crimes, such as assaults on staff or other youth.

It is interesting that a large percentage (85.7%) of the youth had incident reports. Not surprisingly, most of the youth in the program were boys (77.0%), and they generated a proportionate 76.5% of the incidents. Girls also generated a proportionately equal amount of incidents, that is girls accounted for 23.0% of the youth in the program and they were responsible for 23.5% of the incidents. These results indicated that neither group was responsible for a disproportionate amount of incidents.

The relationship between incident reports and the point-level system deserves some discussion. Clearly, the Group Workers used the incident reports as a way to document behaviors that resulted in sanctions within the point-level system. In this way, a strong connection was made between negative behaviors and progress within the program levels. The criteria required for a youth to remove the sanction were clear and unambiguous, and this no

## 2017 COMPARISON OF YOUTH DEMOGRAPHICS




doubt reminded the Group Workers about the criteria and helped facilitate conversations with the youth. The Group Workers' professional judgement was an important factor in deciding what events should warrant an incident report, and in this way it was possible that there were differences between Group Workers about what behaviors should and shouldn't trigger an incident report. It is likely that this subjectivity caused some challenges for the youth if they received different treatment from different Group Workers, especially if sanctions were involved.

Finally, it is worth noting that there was an increase in Unauthorized Departures from a Court Program (UDCP) during 2017, when the program moved from the secure setting to a residential setting. This seems logical, given the fact that youth were no longer locked inside the facility, and could leave the program at any time. The more curious result is that the number of UDCPs decreased in 2018. There are several explanations for this phenomena--one could be that the particular cohort of youth in 2018 were somehow less inclined to depart the program. The other more likely reason could be that the treatment milieu was such that youth were more likely to remain in the program.

## A COMPARISON OF YOUTH OUTCOMES FOR 2017

This section describes the outcome comparisons between two groups for 2017. One group was the 33 youth who participated in the Phoenix Treatment Program and the other group was the 80 adjudicated youth who did not participate in the program and received other Lane County Youth Services interventions. The year 2017 was chosen because it was far enough back in time to allow for a 12-month recidivism analysis. Comparisons between

IN 2017 NEARLY 70% OF YOUTH IN THE PHOENIX TREATMENT PROGRAM WERE "EARLY STARTERS" COMPARED TO LESS THAN 20% IN THE NON-PHOENIX GROUP

the two groups were made on demographic characteristics, age of first referral, average number of criminal referrals before 2017, average number of criminal referrals during 2017, average number of referrals during 2018, JCP Risk Assessment scores as of 1/1/2017, JCP Risk Assessment scores as of 1/1/2018, JCP Risk Assessment scores as of 1/1/2019, 12-month recidivism rate, and locations of youth as of 1/1/2019.

## METHOD

All of the data were collected from Oregon's Juvenile Justice Information System (JJIS). JJIS is a statewide computerized data base that is a single source of information about a youth's contact with the state's juvenile justice system. The evaluator obtained permission to access JJIS from a secure computer terminal located in the Lane County Youth Services building. The evaluator also obtained permission to access the Oregon Circuit Court adult criminal records data base, and a search was conducted for any youth in the evaluation that had turned 18 years old in order to locate any adult criminal referrals that should be included in the 12-month recidivism calculation. Information from JJIS was exported to Excel spreadsheets for the purpose of analyzing the data. Simple frequency counts and percentages were calculated for the various outcome variables and the two groups were compared.

## RESULTS

*2017 Youth Referral Process into the Phoenix Treatment Program*: This evaluation includes a comparison of outcomes for youth who participated in the program during 2017 with youth who did not participate in the program but received other Lane County Youth Services interventions. For purposes of illustration, the referral process for youth during 2017 is described here to help the reader better understand the "flow" of youth into the program.

The referral pathway into the Phoenix Treatment Program in 2017 was narrow, and ultimately a small number of youth were potentially available to participate, and an even smaller number were referred. It helpful to examine broader demographic characteristics in order to contextualize the phenomena of "available youth" for the program. From a macro view, in 2017 there were approximately 374,000 people living in Lane County (U.S. Census estimate, 2017). Of the Lane County population, there were approximately 28,000 youth ages 12 to 17 years old. According to the Juvenile Justice Information System (JJIS) 993 (approximately 3.5% of the youth population) of those youth committed crimes and that generated 1,475 referrals to Lane County Youth Services. Of those referrals, 872 (59%) were criminal referrals (Person, Property, Public Order, Substance/Alcohol, Other Criminal), 442 (30%) were noncriminal referrals (Alcohol/MIP, Curfew, Marijuana Offenses, Tobacco, Non-Criminal Other), and 161 (11%) were Dependency Status referrals (Runaway).

The 1,475 referrals to Lane County Youth Services generated 1,021 dispositions (how the cases were resolved). Most youths' cases resulted in a decision to not petition the court for formal involvement. For example, 291 (29%) youth cases were reviewed and closed, and

587 (57%) youth cases resulted in diversion or informal disposition. There were 143 (14%) cases resulting in a formal petition to the juvenile court. Of those 143 formal petitions, 20 (14%) were dismissed, seven (5%) received an alternate process, three (2%) were remanded to adult court, and 113 (79%) were adjudicated as delinquent.

Of the 113 youth adjudicated as delinquent, 13 (12%) received formal sanctions, 64 (56%) received probation, 18 (16%) received probation and Oregon Youth Authority (OYA) commitment for community placement, and 18 (16%) were committed to an OYA youth correctional facility. Therefore, there were a total of 95 youth (13 formal sanctions, 64 probation, 18 probation and OYA commitment for community placement) who were potentially available for the Phoenix Treatment Program. Of the 95 youth potentially available, 33 were referred to the Phoenix Treatment Program.

## YOUTH CHARACTERISTICS

The youth in the Phoenix Treatment Program in 2017 were generally white males, just slightly older than 15 years, medium to high risk, classified as "early starters," with few protective factors. In 2017, a total of 33 (23 boys and 10 girls) youth participated in the Phoenix Treatment Program, and it is important to understand that there was "overlap" with 2016 and 2017. That is, some of the youth started the Phoenix Treatment Program in 2016 and ended their participation in 2017, and some of the youth started in 2017 and ended their participation in 2018. Most of the youth identified as White (72.6%). The average age of youth when they started was 15.6 years old, and they spent an average 165.5 days in the program. The average risk score (JCP assessment) before the Phoenix Treatment Program was 16.4 for boys and 14.9 for girls (maximum 24), placing them in the medium to high risk category. Girls started the program with a higher average number of protective factors than boys, 2.9 compared to 2.4. Boys started the program with more referrals than girls, averaging 6.5 referrals per boy compared to 4.8 referrals per girl. The average ORS Severity Score (based on severity and frequency of crime) for boys entering the program was 6.4 compared to 7.7 for girls.

IN 2017 YOUTH WHO STARTED THE PHOENIX TREATMENT PROGRAM HAD MORE REFERRALS (5.1 PER YOUTH) COMPARED TO THE NON-PHOENIX YOUTH (3.2 PER YOUTH)

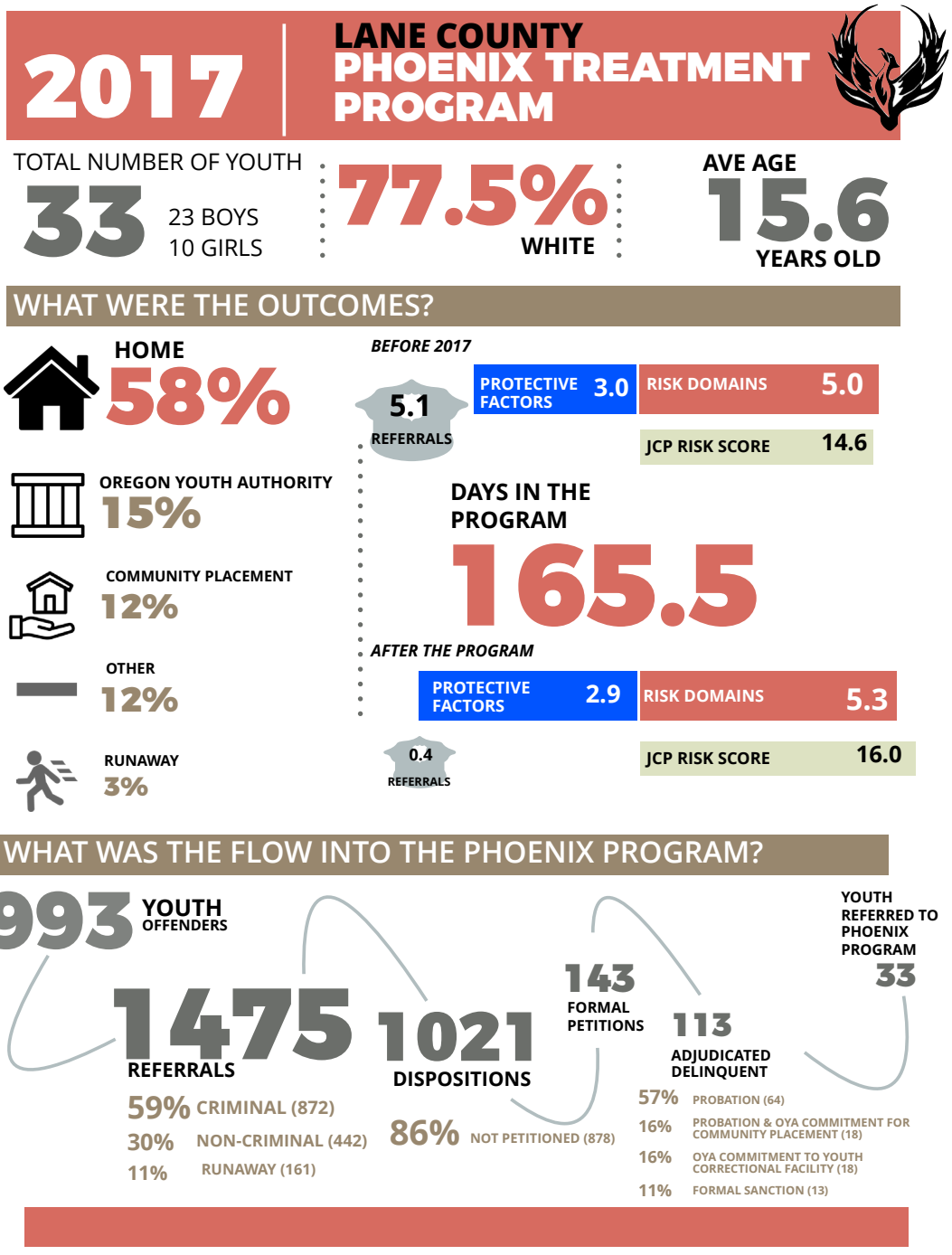
YOUTH WHO PARTICIPATED IN THE PHOENIX TREATMENT PROGRAM IN 2017 RECIDIVATED LESS (27.3%) COMPARED TO NON-PHOENIX YOUTH (35.0%)

*Racial Demographic Comparisons to Other Populations:* The racial demographics of the 33 youth who participated in the Phoenix Treatment Program in 2017 were compared with five other populations to highlight differences between the groups and to illuminate any disproportionate minority contact (DMC). DMC occurs when the proportion of minority youth in the selected group is higher than what is found in the general population. In this case, the general population comparator was the state of Oregon in 2017.

## TABLE 5: 2017 COMPARISON OF PHOENIX TREATEMENT YOUTH WITH NON-PHOENIX TREATMENT YOUTH

| DESCRIPTION | TOTAL YOUTH | PHOENIX TOTAL | PHOENIX BOYS | PHOENIX GIRLS | NON-PHOENIX TOTAL | NON-PHOENIX BOYS | NON-PHOENIX GIRLS |
|---|---|---|---|---|---|---|---|
| Number of Youth | 113 | 33 | 23 | 10 | 80 | 57 | 23 |
| White | 72.8% | 72.6% | 65.0% | 90.0% | 72.9% | 74.0% | 70.0% |
| Hispanic | 10.8% | 9.1% | 13.0% | 0.0% | 11.6% | 11.0% | 13.0% |
| Native American | 8.0% | 9.1% | 13.0% | 0.0% | 7.6% | 7.0% | 9.0% |
| Asian | 3.4% | 3.0% | 0.0% | 10.0% | 3.6% | 5.0% | 0.0% |
| African American | 5.0% | 6.3% | 9.0% | 0.0% | 4.4% | 3.0% | 8.0% |
| Average Age (years) at First Referral | 14.2 | 13.4 | 12.6 | 14.2 | 15.1 | 15.1 | 15.0 |
| Percent "Early Starters" | 33.7% | 69.7% | 78.3% | 50.0% | 18.8% | 21.1% | 13.0% |
| Average Number of Referrals before 2017 | 4.2 | 5.1 | 5.7 | 3.8 | 3.2 | 3.3 | 3.0 |
| Average Number of Referrals during 2017 | 2.2 | 1.7 | 1.7 | 1.8 | 2.7 | 2.9 | 2.2 |
| Average Number of Referrals during 2018 | 0.5 | 0.4 | 0.4 | 0.4 | 0.7 | 0.7 | 0.6 |
| JCP Risk Assessment as of 1/1/17 | | | | | | | |
| Risk Domains (max 6) | 4.8 | 5.0 | 5.1 | 4.9 | 4.8 | 4.8 | 4.7 |
| Risk Indicators (max 24) | 14.3 | 14.6 | 15.3 | 13.1 | 14.2 | 14.2 | 14.3 |
| Protective Factors (max 6) | 2.7 | 3.0 | 2.8 | 3.3 | 2.6 | 2.6 | 2.5 |
| Risk Score (max 30) | 14.2 | 14.6 | 15.1 | 13.3 | 14.1 | 14.1 | 14.0 |
| JCP Risk Assessment as of 1/1/18 | | | | | | | |
| Risk Domains (max 6) | 5.1 | 5.3 | 5.3 | 5.4 | 4.9 | 4.8 | 5.3 |
| Risk Indicators (max 24) | 15.6 | 16.0 | 15.9 | 16.2 | 15.5 | 15.0 | 16.6 |
| Protective Factors (max 6) | 2.7 | 2.9 | 2.8 | 3.0 | 2.6 | 2.7 | 2.3 |
| Risk Score (max 30) | 15.5 | 15.8 | 15.7 | 16.1 | 15.4 | 14.9 | 16.5 |
| JCP Risk Assessment as of 1/1/19 | | | | | | | |
| Risk Domains (max 6) | 5.1 | 5.1 | 5.0 | 5.4 | 5.1 | 5.1 | 5.1 |
| Risk Indicators (max 24) | 14.7 | 15.5 | 15.2 | 16.1 | 14.4 | 14.4 | 14.5 |
| Protective Factors (max 6) | 2.9 | 3.0 | 2.9 | 3.1 | 2.9 | 2.8 | 3.2 |
| Risk Score (max 30) | 13.6 | 14.7 | 14.7 | 14.7 | 13.2 | 13.2 | 13.2 |
| 12-month Recidivism Rate | 32.7% | 27.3% | 26.1% | 30.0% | 35.0% | 35.1% | 35.1% |
| Living Arrangement as of 1/1/19 | | | | | | | |
| Home/Relative's Home/Sibling's Home | 56.3% | 57.7% | 56.7% | 60.0% | 55.7% | 51.8% | 65.2% |
| OYA Youth Correctional Facility (YCF) | 13.4% | 15.1% | 13.0% | 20.0% | 12.7% | 16.1% | 4.3% |
| Other | 9.8% | 12.1% | 13.0% | 10.0% | 8.8% | 12.4% | 0.0% |
| OYA Community Placement | 8.9% | 12.1% | 13.0% | 10.0% | 8.9% | 8.9% | 8.8% |
| Runaway | 5.3% | 3.0% | 4.3% | 0.0% | 6.3% | 3.6% | 13.0% |
| Foster Care | 2.6% | | | | 2.6% | 3.6% | 0.0% |
| Lane County Detention | 2.6% | | | | 2.6% | 3.6% | 0.0% |
| Out of State | 1.3% | | | | 1.3% | 0.0% | 4.4% |
| Shelter Facility | 1.2% | | | | 1.2% | 0.0% | 4.3% |

## 2017 SUMMARY OF PHOENIX TREATMENT YOUTH OUTCOMES



IN 2017 THE PHOENIX TREATMENT YOUTH STARTED AT A HIGHER RISK LEVEL BUT RECIDIVATED LESS OFTEN COMPARED TO THE NON-PHOENIX YOUTH

*Disproportionate Minority Contact (DMC):* Nearly three-quarters of the Phoenix Treatment Program youth identified as white (72.6%), which was nearly the same as Oregon (75.8%), less than Lane County (89.3%), less than youth referred to Lane County Youth Services (80.7%), nearly the same as non-Phoenix youth (72.9%), and more than youth referred to OYA (56.0%). There was DMC compared to the percentage of African Americans in the state of Oregon--6.3% in the Phoenix Treatment Program compared to 2.2% in Oregon. Lane County's population was 1.2% African American, 4.1% youth referred to Lane County Youth Services, 4.4% non-Phoenix youth, and 12% youth referred to OYA. There was not DMC compared to the percentage of Hispanic people in Oregon—9.1% in the Phoenix Treatment Program compared to 13.1% in the state. Lane County's population was 8.9% Hispanic, 7.3% youth referred to Lane County Youth Services, 11.6% non-Phoenix youth, and 23% youth referred to OYA. There was not DMC compared to the percentage of Asian people in Oregon—3.0% in the Phoenix Treatment Program compared to 4.7% in the state. Lane County's population was 3.1% Asian, 1.7% youth referred to Lane County Youth Services, 3.6% non-Phoenix youth, and 1.0% youth referred to OYA. There was DMC compared to the percentage of Native American, Native Hawaiian and Pacific Islander—9.1% in the Phoenix Treatment Program compared to 2.2% in the state. Lane County's population was 1.8%, 1.6% youth referred to Lane County Youth Services, 7.6% non-Phoenix youth, and 5.0% referred to OYA.

*Special Education Diagnosis:* Research has shown that juvenile justice involved youth have higher rates of special education diagnoses compared to their non-juvenile justice involved counterparts, and similar trends were observed in this sample. For the 33 youth included in this evaluation, 30.3% had a special education diagnosis. This compared with 23.8% of the adjudicated youth that did not participate in the Phoenix Treatment Program in 2017. Nationally, about 12% to 15% of all K-12 students have a diagnosed special education disability (Kleiner, Porch, & Farris, 2002; U.S. Department of Education, 2014).

*Early Starters:* The age of first arrest is another way to categorize risk of reoffending. Researchers have identified age of first arrest as an important milestone in a youth's development, and the literature generally identifies age 14 as the break point between two groups: Early Starters and Late Starters (Alltucker, Bullis, Close & Yovanoff, 2006). Early Starters are arrested before age 14 and have a longer, more complex criminal development compared to Late Starters, and are at a higher risk of reoffending compared to Late Starters (Loeber & Farrington, 1998). Early Starters' development is typically characterized by negative family experiences and early trauma, including violence, and child abuse and neglect. As such, it is important that treatment programs recognize the different needs of

THE FACT THAT MOST OF THE PHOENIX YOUTH WERE "EARLY STARTERS" AND YET RECIDIVATED LESS THAN THE NON-PHOENIX YOUTH WAS REMARKABLE

THE PHENOMENOM OF RISK SCORES INCREASING DURING THE PROGRAM MIGHT BE EXPLAINED BY "MORE EYES ON THE YOUTH"

these two groups so that effective interventions can be implemented. In the Phoenix Treatment Program, 75% of the boys were Early Starters, and 50% of the girls were Early Starters.

There were differences in the age of first referral between the two groups, with the PTP youth having a younger age of first referral (13.4 years) compared to 15.1 years for the NP group. There was a large difference in the percentage of youth who were early starters (referral before age 14). The PTP group had 69.7% early starters, compared to only 18.8% early starters in the NP group.

*Gender and Race:* The Phoenix Treatment Program group (PTP) and the Non-Phoenix (NP) groups compared closely on gender and racial variables. The PTP group was 69.7% boys and 30.3% girls, compared to the NP group 71.3% boys and 28.7% girls. Racial demographics were comparable as well. The PTP youth identified as 72.6% White (72.9% NP), 9.1 % Hispanic (11.6% NP), 9.1 % Native American (7.6% NP), 3.0% Asian (3.6% NP), and 6.3% African American (4.4% NP).

*Number of Referrals:* There were noteworthy differences in the number of referrals in each group. The PTP youth had an average of 5.1 referrals per youth prior to beginning the program in 2017, compared to an average of 3.2 referrals per youth in the NP group at the beginning of 2017. During 2017, when the PTP youth were participating in the program, they had fewer average referrals per youth (1.7) compared to the NP youth (2.7) during the same time period. During 2018, when most of the youth had completed the program, PTP youth had slightly fewer average referrals per youth (0.4) compared to the NP youth (0.7).

*JCP Risk Assessment Scores:* The JCP scores between the two groups illustrated some differences. The average JCP risk scores as of 1/1/17 for the PTP youth were slightly higher, as were the protective factors: risk score (14.6 PTP, 14.1 NP), risk indicators (14.6 PTP, 14.2 NP), risk domains (5.0 PTP, 4.8 NP), protective factors (3.0 PTP, 2.6 NP).

*JCP Risk Scores Immediately after Treatment:* The average JCP risk scores as of 1/1/18 (when most of the youth had completed the PTP) showed an increase in risks and a decrease on protective factors for the PTP youth, and a similar increase in risks for NP youth. The protective factors for NP youth remained constant: risk score (15.8 PTP, 15.4 NP), risk indicators (16.0 PTP, 15.5 NP), risk domains (5.3 PTP, 4.9 NP), protective factors (2.9 PTP, 2.6 NP).

*JCP Risk Scores 12-months after Treatment:* The average JCP risk scores as of 1/1/19 (approximately 12 months post treatment) showed improvement in the PTP youth and mixed results for the NP youth compared to the

THE 12-MONTH RECIDIVISM RATE FOR YOUTH WHO PARTICIPATED IN THE PHOENIX TREATMENT PROGRAM WAS LOWER THAN THE OVERALL LANE COUNTY RECIDIVISM RATE, AND LOWER THAN THE STATE OF OREGON RECIDIVISM RATE

IN 2017, YOUTH WHO PARTICIPATED IN THE PHOENIX TREATMENT PROGRAM ESCALATED TO OYA YOUTH CORRECTIONAL FACILITIES AT A HIGHER RATE THAN NON-PHOENIX YOUTH (15.1% VERSUS 12.7%)

previous time period. Both groups had a slight increase in the average number of protective factors: risk score (14.7 PTP, 13.2 NP), risk indicators (15.5 PTP, 14.4 NP), risk domains (5.1 PTP, 5.1 NP), protective factors (3.0 PTP, 2.9 NP).

*Recidivism Rate:* The 12-month recidivism rates were lower for the PTP youth compared to the NP youth for both boys and girls. The overall 12-month recidivism rate for the PTP youth was 27.3% (26.1% boys, 30.0% girls) compared to 35.0% for the NP youth (35.1% boys, 34.7% girls).

*Locations:* There were differences between the two groups on the youth locations as of 1/1/19. Most youth in both groups were living in their home, a relative's home, or a sibling's home. The PTP youth had a slightly higher percentage in this category (57.7%) compared to the NP youth (55.7%), and there were differences between sexes (56.7% PTP boys, 51.8% NP boys; 60.0% PTP girls, 65.2% NP girls). There were large differences between the groups with the number of youth referred to an OYA Youth Correctional Facility. PTP youth had higher percentages (15.1%) compared to NP youth (12.7%), especially for girls (20.0% PTP girls, 4.3% NP girls). PTP boys had a smaller percentage (13.0%) compared to NP boys (16.1%) referred to OYA close custody. The PTP youth had higher percentages (12.1%) referred to OYA Community Placements compared to the NP youth (8.9%). There were similar differences for boys and girls between the two groups: PTP boys (13.0%), NP boys (8.9%); PTP girls (10.0%), NP girls (8.8%). There were marked differences in the rates of runaways between the two groups. In the PTP group, 3.0% of the youth were runaways (4.3% boys, 0.0% girls), compared to 6.3% in the NP group (3.6% boys, 13.0% girls). A small number of NP youth were referred to foster care, Lane County detention, out of state, or shelter facilities.

## DISCUSSION

This portion of the evaluation examined differences between the 33 youth who participated in the Phoenix Treatment Program during 2017, compared to the 80 adjudicated youth who did not participate in the Phoenix Treatment Program during the same time. Demographic differences were noted and several outcome variables were measured. While this exercise deepens the understanding of the Phoenix Treatment Program, there were significant limitations that should be highlighted in order to properly consider the outcomes. First, this study utilized a non-scientific design and therefore the outcomes cannot be attributed solely to the effects of the Phoenix Treatment Program. The relationships are correlational and caution should be exercised when contemplating cause and effect relationships. Second, the sample sizes were relatively small, so any numerical changes in outcome variables had a disproportionately large effect on percentages.

That said there were many interesting differences between the two groups that merit discussion. The largest and perhaps most glaring difference was the number of "early starters" in the Phoenix Treatment Program group compared to the Non-Phoenix group. Nearly 70% of the youth in the Phoenix Treatment Program were early starters, compared to less than 20% in the Non-Phoenix

group. This is remarkable because the literature is clear about the developmental trajectory of early starters. Compared to late starters, early starters are much more likely to have a more complex and extensive trauma history, are more likely to experience emotional and behavioral disruptions, and are more likely to continue their criminal behaviors into adulthood (Eddy, Reid, & Curry, 2002; Loeber & Farrington, 2001; Patterson, Capaldi, & Bank, 1991; Patterson, Crosby, & Vuchinich, 1992). While the sheer number of early starters in the Phoenix Treatment Program group was impressive, the fact that the Phoenix Treatment Program youth had many instances of improved outcomes compared to the Non-Phoenix youth was even more remarkable. For example, the Phoenix Treatment Program youth started the program with more referrals, and higher JCP risk scores than the Non-Phoenix group, and yet the Phoenix Treatment Program youth recidivated at a lower rate compared to the Non-Phoenix youth. There was a slight increase in the Phoenix Treatment Program youths' risk scores and a slight decrease in their protective factors, at 1/1/2018 which was when most of the youth had recently completed the program.

These increases might seem paradoxical given the close temporal proximity to the program completion—why would risk scores increase and protective factors decrease? The reasons might be partially explained by anecdotal reports from JCs who observed that it is not uncommon for risk scores to increase and protective factors to decrease during the time that a youth is heavily involved in the system. This is because there are more "eyes" on the youth, and more information is known about the youth's family, friends, school, substance use, and attitudes and beliefs that support criminal behavior. That is, the longer a youth is involved in the juvenile justice system, the more opportunities there are to learn details about their lives—and sometimes to learn about increased risk factors and decreased protective factors. It is not unusual for a youth to be reassessed multiple times using the JCP risk assessment tool, and therefore it is not unusual for risk scores to increase and protective factors decrease.

The changes in the "private events" in the Phoenix Treatment Program youth were impressive, but perhaps the most notable and most impactful differences were in the "public events" of recidivism. On average, the Phoenix Treatment Program youth recidivated 22% less compared to the Non-Phoenix youth. There were also differences between sexes, with the Phoenix Treatment Program boys recidivating 25.6% less than the Non-Phoenix boys, and the Phoenix Treatment Program girls recidivating 13.5% less than the Non-Phoenix girls. The 12-month recidivism rate for the Phoenix Treatment Program also compared favorably to the Oregon and Lane County rates. The 12-month recidivism rate for the Phoenix Treatment Program youth in 2017 was 27.3% compared to 30.7% for Lane County and 28.8% for the state of Oregon (JJIS, 2018).

Other "public events" outcomes that are important to discuss were the locations of the Phoenix Treatment Program youth after completing the program. While the rates of family reunification were comparable between the two groups, it is salient to note that the Phoenix Treatment Program youth started out at higher risk than the Non-Phoenix group, and because of the predominance of early starters, the Phoenix Treatment Program youth were much more likely to have negative outcomes. So, it is notable that the percentage of youth living at home, or a relative's home was about the same between the two groups.

Some of those early starters in the Phoenix Treatment

Program youth escalated into an OYA Youth Correctional Facility, although individual youth were not examined. Slightly more than 15% of the Phoenix Treatment Program youth were referred to OYA close custody, compared to 12.7% of the Non-Phoenix youth, with the differences explained by the rates of referrals for girls. While the Phoenix Treatment Program boys were referred to OYA close custody less than the Non-Phoenix boys (13.0% versus 16.1%), the Phoenix Treatment Program girls were referred at a higher rate compared to the Non-Phoenix girls (20.0% versus 4.3%). It is possible that the particular cohort of girls in the Phoenix Treatment Program during 2017 were particularly antisocial and exhibited increased criminal behaviors. The analyses performed for this evaluation used aggregated data and did not examine individual outcomes.

In summary, the outcomes for the Phoenix Treatment Program compare favorably with the outcomes of the Non-Phoenix youth for 2017. This will likely be a key point in discussions regarding how the Phoenix Treatment Program might change to better serve the needs of the vulnerable and high risk youth and families involved in the program.

## PHOENIX TREATMENT PROGRAM QUALITATIVE OUTCOMES

This section describes the qualitative outcomes for two important groups: youth and families participating in the Phoenix Treatment Program, and Lane County Youth Services personnel who work with the Phoenix Treatment Program in various capacities. Qualitative methods are well known to provide information regarding how programs work, the processes believed to bring about positive changes in behavior, examining contextual components that might affect outcomes, exploring what the outcomes mean for participants, and perhaps uncovering unintended program side-effects (Patton 2002; Stake 2005). There is a small amount of quantitative data included in this section that describes the results of a short survey administered to three youth who participated in the Phoenix Treatment Program during 2018.

> "QUALITATIVE ANALYSIS IS GUIDED NOT BY HYPOTHESIS BUT BY QUESTIONS, ISSUES, AND A SEARCH FOR PATTERNS"
>
> PATTON, 1987, P. 15

Documenting the qualitative experiences of youth and families who participated in the Phoenix Treatment Program, and the experiences of Lane County Youth Services personnel who work with the program provided important information for this evaluation, even though the youth and families that were interviewed were not the same youth and families who were included in the quantitative analysis for the year 2017. Most of the Lane County Youth Services personnel who were interviewed were working with the Phoenix Treatment Program during 2017 and therefore provided contextually relevant experiences, perspectives and attitudes about the program.

## QUALITATIVE METHOD: EXPERIENCES OF YOUTH AND FAMILIES

While it was recognized that the program evaluation efforts were not scientific research (the efforts were not intended to develop or contribute to generalizable knowledge), the evaluator chose to follow protocols for the protection of human subjects as required by Institutional Review Board (IRB) standards. More specifically, the University of Oregon's Office of Human Subjects

THREE YOUTH AND THREE PARENTS WERE INTERVIEWED TO GET THEIR EXPERIENCES AND PERCEPTIONS ABOUT THE PROGRAM

Protection provided guidance to develop informed consent/assent documents for the families and youth involved in the Phoenix Treatment Program. In order to comply with IRB standards, the informed consent/assent described the purpose and details of the study; participation was voluntary and could be stopped at any time without consequences, the risks of participating, the benefits of participating, what would happen with the information collected, and the name and contact information of the evaluator.

Using this guideline, the evaluator developed three forms to facilitate informed consent. One form was for the parent/guardian consent to participate in the evaluation themselves, one form was for the parent/guardian consent and permission for their son or daughter to participate in the evaluation, and one form was for the youth to assent their own participation in the evaluation. Assent is the agreement of someone who is not able to give legal consent—in this case; the youth were not able to give legal consent because they were younger than 18 years of age. The consent/assent forms were approved by the Lane County Health and Human Services Compliance office on June 5, 2018. Copies of the consent/assent forms are included in the Appendices of this report.

*Developing Rapport:* The evaluator spent approximately 40 hours of direct observation in the Phoenix Treatment Program, typically between the hours of 8:00 AM and 5:00 PM. The purpose of spending time in the program was to not only develop a deeper and more meaningful understanding of the program, but more importantly to establish a level of trusting relationships with the staff and the youth. The evaluator was aware that youth involved in the juvenile justice system, and specifically in residential treatment programs are typically initially distrustful of adults who they perceive to be part of the system. The evaluator spent time in the common areas of the building and greeted youth as they went about their daily routines and meals. Over a period of days, some of the youth became friendly towards the evaluator, and were curious about the project. The evaluator explained the project and offered opportunities for the youth to add their voices to the evaluation if they wanted.

*Interviews:* Between the months of June and October 2018, the evaluator obtained permission to interview three youth. Three parents/guardians agreed to be interviewed. The evaluator met with the youth individually on-site and completed a semi-structured interview lasting approximately 30 minutes. There were three basic questions to the semi-structure interviews: what worked well in the program, what did not work well in the program, and what changes would you like see in the program. In order to gain additional contextual information about the treatment milieu, the evaluator regularly reviewed the shift reports that were completed by staff, and compiled on a secure computer drive. The shift reports include information about youth behavior during the shift, any significant behavioral issues, and any incidents that occurred.

The evaluator met with one parent/guardian off-site and completed a semi-structured interview lasting approximately one hour. The evaluator met with another parent/guardian on-site and conducted an informal unstructured interview that lasted approximately five

minutes. The other parent/guardian interview was on the phone and lasted about 15 minutes. Immediately following the interviews, the evaluator wrote the major conversation themes to document the qualitative information.

*Satisfaction Survey Data:* In addition to the qualitative data collection from the youth, the evaluator also collected quantitative data via the Client Satisfaction Inventory Short Form (CSI-SF), a nine-item standardized instrument developed by McMurtry and Hudson (2000) designed to measure client satisfaction with human services. The nine questions were:

- People here seem to care about me
- I would come back here if I needed help again
- I would recommend this place to people I care about
- People here seem to know what they are doing
- I get the kind of help here that I really need
- People here accept me for who I am
- People here seem to understand how I feel
- I feel I can really talk to people here
- The help I get here is better than I expected

The scale is a 7-point, category-partition scale with responses ranging from 1 (none of the time) to 7 (all of the time). The evaluator obtained permission from the CSI-SF originators in 2014 to use the instrument in the Phoenix Treatment Program.

YOUTH PERCEIVED STAFF AS CARING AND EFFECTIVE ADULT ROLE MODELS

The CSI-SF surveys were completed by the youth during the interviews.

## RESULTS: EXPERIENCES OF YOUTH AND FAMILIES

The qualitative data were organized using the three interview questions as an analytical framework (cross case format), and were analyzed utilizing a content analysis (Patton, 2002). This involved identifying the coherent and consistent themes and patterns that emerged from the interview questions. An inductive analysis was used, meaning the themes and patterns emerged from the data (Patton, 1987). Two boys and one girl were interviewed.

YOUTH VOICED A GENERAL DISSATISFACTION WITH THE POINT-LEVEL SYSTEM

## YOUTH

The prominent themes and patterns emerging from the youth responses were centered on five issues: staff, autonomy, the point-level system, legitimacy, and the residential treatment milieu.

*Staff:* Youth perceived staff as caring and effective adult role models that were readily available to help, listen and provide positive guidance.

*Autonomy:* Not surprisingly, youth wanted more autonomy in making decisions and wanted more say in how things were done in the program—specifically around the issues of rewards and how to advance in the program in ways

that were relevant to the individual youth. Several youth commented on their desire to be able to wear jewelry and other individualized clothing items that were meaningful, such as jeans with holes and rips in the fabric.

*Point-level System:* There was a general distaste for the point level system, which was perceived to be a rigid, non-individualized and somewhat arbitrary system of rewards and punishments. Some of the youth perceived the point level system as punishing them for their inherent personality traits or tendencies (e.g. ADHD behaviors, inability to wake up quickly in the morning). One youth reported that a mix up that caused a two week delay in getting correct prescription medications, contributed to behaviors that resulted in punishments and lack of progress in the point level system. Some youth commented that the point level system was not relevant to their lives outside of the program—that is, they believed the point level system did not help them attain meaningful skills that they needed to be successful in their families and communities.

*Legitimacy:* Despite the negative feelings towards the point level system, the youth felt that the overall program demonstrated legitimacy in that it provided education and training in skills that the youth believed to be useful in their lives outside of the program. One youth commented that the homework required for advancement through the program was not particularly useful or challenging.

*Residential Treatment Milieu:* There was a general sense that living together in close quarters for many hours of the day presented challenges for the youth who reported that they were at times frustrated and "fed up" with the antics and behaviors from their fellow program participants. The only girl interviewed for the evaluation commented on the frustrations of living with teenage boys and the fact that constant efforts to maintain proper boundaries

YOUTH SAID THEY SOMETIMES GOT "FED UP" WITH LIVING IN CLOSE QUARTERS WITH OTHER TEENAGERS

and behaviors were exhausting, and that sometimes she chose to avoid potentially challenging interactions by retreating to her room. In many instances, this resulted in her missing group sessions, or community outings. While the girl did not specifically mention any concerns about safety, the evaluator was made aware of an incident (from a review of the daily shift notes) involving a boy in the program who made an inappropriate sexual advance towards the girl, resulting in the boy being terminated from the program.

*Quantitative analysis:* The Client Satisfaction Inventory Short Form (CSI-SF) was scored using McMurtry and Hudson's (2000) formula. The maximum score is 100, with higher scores indicating greater client satisfaction.

$S$ = Total Score

Y = Score for item

N = Number of items correctly completed by the respondent

Three Client Satisfaction Inventory Short Form (CSI-SF) were completed and the total scores were calculated:

$S_1$ = 66.7

$S_2$ = 92.6

$S_3$ = 100.0

The average score $S_{ave}$ = 86.4

## FAMILIES: PARENTS/GUARDIANS

The prominent themes and patterns emerging from the parent/guardian responses were centered on four issues: staff, program structure, accountability, and legitimacy.

*Relationships with Staff:* In general, parents/guardians felt that their youth had established meaningful and therapeutic relationships with program staff members, and the relationships had facilitated positive behavioral changes in their youth.

*Structure:* All of the parent/guardians reported they were grateful for the structured environment that the program provided their youth because it forced their youth to be accountable for their actions and behaviors. Several of the parents/guardians commented that the program was able to provide the structure and accountability that they were not successful in providing in their home, and that they hoped the positive behavior changes they observed in their youth would continue after their youth returned home.

*Legitimacy:* There were two subsets of issues within the general heading of legitimacy. One parent voiced strong concerns about the effectiveness and relevancy of the program's mental health and drug and alcohol treatment services, voicing desires that the program more closely align with 12-Step treatment models. Another parent voiced concerns about the lack of gender-specific services.

## DISCUSSION: EXPERIENCES OF YOUTH AND FAMILIES

YOUTH AND FAMILIES BELIEVED THE PHOENIX TREATMENT PROGRAM STAFF WAS EFFECTIVE

Certain limitations of this portion of the program evaluation should be recognized before considering what, if any, conclusions might be drawn from its results. First, the sample sizes were extremely small. While this is not inherently problematic in qualitative research, more youth and families would have added complexity and detail to the data. The evaluator found it extremely difficult to obtain parental permission to interview their youth. There are likely several reasons for this. One is that many of the families with youth in the program were likely overwhelmed with the logistics of trying to juggle their regular family obligations such as caring for their other sons or daughters who were living at home, employment obligations, and the general business of daily life. It is likely that families did not want another Lane County Youth Services person poking into their family life and asking to intrude on their time to ask questions about their experiences with the program.

Some of the youth naturally gravitated towards the evaluator and were very interested in giving their feedback and perceptions about the program, but other youth were not interested. It is possible that the characteristics of the youth who volunteered to participate in the evaluation (and whose parents gave permission) were different than the youth who chose not to participate in the evaluation, and that important qualitative data were missed because of this. The same can be said about the parents/guardians who agreed to participate with the evaluation—there were no parents/guardians of youth who were not successful in the program included in the evaluation, and therefore, important feedback about their perceptions were not included.

An important limitation to the quantitative data was that the surveys were completed very close to the time the youth were successfully transitioning out of the program.

YOUTH AND FAMILIES QUESTIONED THE RELEVANCY OF SOME OF THE "HOMEWORK"

It is likely that there was a "halo" effect—the youth were pleased to be nearly completed with the program, and therefore were more likely to be positive about the program. It would be interesting to interview youth who were not successful in the program to obtain their perspectives about what did not work for them. Finally, the Client Satisfaction Inventory Short Form (CSI-SF) was a self-report measure, and therefore was inherently susceptible to biases based on the youths' perceptions of effectiveness. That said, the information gained from the interviews and surveys provided important data regarding the program.

*Effectivenss of Staff:* One of the prominent themes found in both the youth and parent/guardian interviews was the effectiveness of the staff. Youth and parents/guardians were generally very positive about the Phoenix Treatment Program staff and their abilities to establish meaningful, trusting and therapeutic relationships. This is referred to as the "therapeutic alliance" and is one of the cornerstones of effective treatment (i.e. Richards & Sullivan, 1996). The ability of front-line personnel to create therapeutic alliances with youth is a tricky balance between emphasizing the youth's responsibilities for their own behavior, with an appropriate level of attention to the youth's emotional needs (Rutter, Giller, & Hagell, 1998). Establishing a therapeutic alliance with youth is also related to the Responsivity Principle of effective treatment for youth involved in the juvenile justice system. The Responsivity Principle is the practice of matching the youth's learning style and abilities with the treatment intervention (Andrews, Bonta, & Wormith, 2011) and is an important feature of best practices.

*Homework:* Another theme found in both the youth data and the parent/guardian data was concerns or dissatisfaction with the homework required to advance through the program. There was a general feeling that the homework was "busywork" and was not particularly useful or relevant, although several of the youth commented positively about the skills they learned in groups, which also had some homework required. This concern relates loosely to the dichotomous categories of "book smart" versus "street smart." For many youth involved in the juvenile justice system, street smart is more highly valued than book smart because street smart is required to successfully navigate their lives filled with poverty, violence, law enforcement, and street culture (Hatt, 2007).

*Gender-Specific Programs:* Concerns about the co-ed program, and the lack of gender-specific treatment for girls were mentioned by a parent/guardian with a girl in the program. There was an incident involving inappropriate behaviors towards the girl, which compromised her safety. These concerns align with the emerging knowledge about what happens when girls are in the same residential treatment program with boys, including risk of re-traumatization, and the continuation of unhealthy gender socialization (National Council on Crime & Delinquency, Center for Girls and Young Women, n.d.). The Office of Juvenile Justice and Delinquency Prevention (OJJDP) recommended in 1998 that programs should be gender specific, and that girls

PARENTS OF GIRLS IN THE PROGRAM WANTED MORE GENDER-SPECIFIC TREATMENT

## YOUTH WANTED MORE AUTONOMY IN DECISION-MAKING

should be in all-female programs.

*Legitimacy of the Point-level System:* Youth were generally not happy with the point level system required to advance in the program because they felt it was unfair at times, had too many punishments compared with rewards, and at times punished youth for behaviors the youth felt were out of their control, such as lack of attention, hyperactivity, or the inability to wake up quickly on command in the morning. These concerns relate directly to legitimacy and perceptions of procedural fairness, which have been shown to be important features in positive behavior change for youth involved in the juvenile justice system (Fagan & Tyler, 2005). Youth are more likely to perceive their treatment as being legitimate if they feel that they have been listened to, the decisions are fair and consistent, the youth was treated with respect, and if authorities acted out of true caring for the youth. If punishments or sanctions are perceived to be unfair, youth (especially youth with low self-control) are more likely to react with anger, which can lead to outright defiance (Piquero, Gomez-Smith, & Langton, 2004), thus point level systems that are applied inconsistently or unfairly can result in increased negative behaviors by the youth, which in turn can create a negatively spiraling situation. Youth who perceive they have been treated fairly, are more likely to accept responsibility for their actions and increase prosocial behaviors (National Research Council, 2013). It should be noted that research has also found racial differences in ratings of procedural justice, with black youth rating lower compared to white youth (Tyler & Huo, 2002).

*Autonomy:* Youth expressed a strong desire to participate in the decision making process, and this relates to autonomy. Autonomy is an important part of identity formation for adolescents and is a natural developmental quest for youth. There is overlap between the constructs of autonomy and legitimacy as both include the need to be heard and a perceived sense of fairness (National Research Council, 2013). Researchers have identified different categories of autonomy, including independence, detachment, agency, and self-governance ( Van Petegem, Beyers, Vansteenkiste, & Soenens, 2012). Each is related to normal adolescent development and therefore should be considered important features to residential treatment programs.

*Youth Satisfaction:* Results from the quantitative Client Satisfaction Inventory Short Form (CSI-SF) were interesting in that they indicated a generally positive level of satisfaction with the Phoenix Treatment Program, but the extremely limited sample size limits the utility of the results.

## EXPERIENCES OF LANE COUNTY STAFF AND TREATMENT PROVIDERS

### METHOD

Lane County staff and treatment providers were important stakeholder in this evaluation, and to that end, the Evaluator emphasized a participatory approach to the evaluation work. The Evaluator met with the Lane County Youth Services Leadership Team on April 27, 2018 at the request of the Youth Services Division Manager, for the purpose of introducing the evaluation project and to begin to define the scope of work, and to create preliminary evaluation questions. During that meeting, the Evaluator communicated the purpose of the evaluation was to document the value of the Phoenix Treatment Program,

## TABLE 6: SUMMARY OF INTERVIEWEES

| Position Title | Number of People Interviewed |
|---|---|
| Phoenix Treatment Program Supervisor (There was a change in Program Supervisors during the evaluation) | 2 |
| Group Workers (including one former Group Worker) | 9 |
| Juvenile Counselors (JCs) | 12 |
| Mental Health Specialist II | 1 |
| Juvenile Court Judge (including one retired judge) | 2 |
| Center for Family Development Therapists and Supervisors | 4 |
| Center for Family Development Treatment Coordinator | 1 |
| Center for Family Development Behavior Support Specialist | 1 |
| Center for Family Development Substance Use Disorder (SUDS) Counselor | 2 |
| Martin Luther King Jr. Education Center Teachers and Administrator | 3 |

*Note: The Evaluator interviewed the Program Directors multiple times which explains why there were 40 interviews conducted with 37 individual people*

and to collect data that would describe the program context, inputs, process, and products (outcomes). The intent of using a participatory approach to the evaluation work was to increase the level of buy-in and utilization of the evaluation findings, and to increase the validity and reliability of the evaluation data (Wholey, Hatry, & Newcomer, 2004). More importantly, the Evaluator wanted to address the natural resistance that sometimes occurs when personnel perceive the evaluation as a threat or that the evaluation will be used to eliminate the program, or judge individual performance. As with the youth and families who participated in the Phoenix Treatment Program (also important stakeholders), the qualitative staff experiences were meaningful component to the evaluation.

Several recruitment methods were used in addition to meeting with the Leadership Team. The Evaluator initially introduced Phoenix Treatment Program staff to the evaluation process by attending two weekly staff meetings where he explained the purpose of the program evaluation, and the proposed scope of work. The Evaluator also communicated with staff (Program Supervisors, Phoenix Treatment Program Group Workers and Program Supervisors, JCs, Judge, Treatment Providers) via email, offering the opportunity to participate in the evaluation. The Evaluator conducted 40 semi-structured interviews with 37 Lane County Youth Services personnel (and former Youth Services personnel) and Treatment Providers between May 9, 2018 and March 1, 2019. Each interview lasted about 20 minutes, for a total time of more than 13 hours of interviews.

All of the interviews were voluntary, and not all staff agreed to be interviewed. The interviews were conducted mainly on-site during working hours. There were three basic questions: What are your experiences with the Phoenix Treatment Program?, What has worked well?, What changes would you like to see in the program? The Evaluator allowed interviewees to answer the open-ended questions and he pursued other lines of inquiry as they presented themselves during the interviews. That is, if the interviewee brought up interesting and relevant information during their answer, the Evaluator asked follow-up questions to provide richer and more complex information about the program. For example, the Evaluator regarded staff as the experts in the program, and if topics came up that the Evaluator was not familiar with, he asked more questions about that topic in order

to increase his understanding, and also to inform the literature review process that occurred after all of the interviews were completed.

The Evaluator took minimal notes during the interviews, and then immediately following, he transcribed the major conversation themes to document the qualitative data.

## RESULTS: EXPERIENCES OF EXPERIENCES OF LANE COUNTY STAFF AND TREATMENT PROVIDERS

The qualitative data were organized using the three interview questions as an analytical framework (cross case format), and were analyzed utilizing a content analysis (Patton, 2002). This involved identifying the coherent and consistent themes and patterns that emerged from the interview answers. An inductive approach was used, meaning the themes and patterns emerged from the data (Patton, 1987).

## PROGRAM SUPERVISORS

During the evaluation there was a change in Program Supervisor. After working for Lane County Youth Services for five years (the Program Supervisor had worked in community-based youth residential programs for many years previously), the Program Supervisor retired on July 3, 2018 and a new Program Supervisor took over the supervision and administration of the Phoenix Treatment Program.

*Prominent themes and Patterns:* The prominent theme and pattern that emerged from the Program Supervisors' interviews aligned directly with the overarching themes of the juvenile justice system: Community Safety, Accountability, and Rehabilitation (Maloney, Romig, & Armstrong, 1988). Within those dominant themes, several patterns emerged, including safety of the youth in the program, the use of secure detention, rehabilitation takes place in context of relationship, responsivity, staff qualifications and training, mental health services, prosocial development, strength-based outcome measures, and the effects of ecological systems on youth development.

| Program Supervisors<br>Summary of Prominent Themes and Patterns |
|---|
| Themes: |
| • Community Safety<br>• Accountability<br>• Rehabilitation |
| Patterns within Prominent Themes: |
| • Safety of youth in the program<br>• Use of secure detention<br>• Rehabilitation takes place in the context of healthy relationships<br>• Responsivity<br>• Staff qualifications and training<br>• Mental health services<br>• Prosocial development<br>• Strength-based outcome measures<br>• Effects of ecological systems on youth development |

## GROUP WORKERS

Seven Group Workers (including a former Group Worker) were interviewed. The length of employment and experience with the Phoenix Treatment Program ranged from newly hired to more than 13 years experience.

*Prominent themes and Patterns:* The prominent themes and patterns that emerged from the Group Worker and Program Supervisor interviews also aligned directly with the overarching themes of the juvenile justice system: Community Safety, Accountability, and Rehabilitation

(Maloney, Romig, & Armstrong, 1988). There were some differences compared with the Program Director interviews. Not surprisingly, the Group Workers and Program Supervisors focused more on program-level issues such as the importance of the treatment milieu, staff support and training, and the need for clear, consistent communications between all parties involved in the youth's case, including the judge, juvenile court counselors, mental health counselors, Martin Luther King school personnel, and Phoenix Treatment Program staff. Within the treatment milieu category, there was a consistent pattern of the challenges presented because of the mixed-gender program, the importance of healthy therapeutic relationships, concerns about the "shelter" youth disrupting the therapeutic environment for the Phoenix Program youth, and the fact that some of the program homework was considered to be "busywork" by some of the youth. There was a clear and consistent pattern that recognized the high level of staff dedication to their jobs and a consistent desire to help the youth. Within the staff support and training category, there were patterns of concern regarding long hours and low staffing levels, although the concerns stemmed from a perceived ideal number of staff to youth ratio in order to maintain supervision of youth in various spaces in the building that were not covered by surveillance cameras. There was recognition that staffing levels were exceeding the minimum levels required by the state of Oregon Behavioral Rehabilitation Services standards. There was also a pattern of recognition that trauma-informed services were important and that program staff training should be centered on trauma informed treatment. There was a desire to improve communication between all parties for the purpose of improving outcomes for the youth in the program. Finally, there were consistent themes of concerns about the point-level system. There were concerns that if the point-level system was eliminated, it would be more difficult for Group Workers to keep youth accountable for their behaviors, and concerns about being able to effectively manage behaviors. Conversely, there were concerns about the validity of the point-level system and questions if it had anything to do with developing skills needed for success outside of the program.

| Group Workers<br>Summary of Prominent Themes and Patterns |
|---|
| Themes: |
| • Community Safety<br>• Accountability<br>• Rehabilitation |
| Patterns within Prominent Themes: |
| • Importance of treatment milieu<br>• Concerns with co-ed program<br>• Concerns with Shelter Youth disrupting the treatment milieu<br>• Some of the youth perceived homework as busywork<br>• Staff support and training regarding trauma-informed treatments<br>• Concerns about low staffing levels--unable to supervise all areas of building<br>• Clear communication between all parties involved with youth<br>• Challenges with co-ed program<br>• High level of staff dedication to job and desire to help youth<br>• Concerns about the Point-level system: need something to keep youth accountable for their behaviors<br>• Not sure if Point-level system develops skills needed for living on outside |

## JUVENILE COUNSELORS

A total of 12 Juvenile Counselors (JCs) were interviewed for the evaluation. The length of employment with Lane

County Youth Services, and the experience with the Phoenix Treatment Program ranged from a few years to nearly 35 years experience. The Lane County Youth Services Mental Health Specialist II was also interviewed. To protect the identity of the Mental Health Specialist, responses were included with the JC responses.

*Prominent themes and Patterns: Accountability:* As with the Program Supervisor, Group Worker and Program Supervisor responses, the Juvenile Counselor and Mental Health Specialist responses conformed well to the underlying foundational themes of the juvenile justice system: Community Safety, Accountability, and Rehabilitation (Maloney, Romig, & Armstrong, 1988). The patterns that were revealed within those themes differed slightly from the previous groups, accentuating programmatic elements relating to accountability and rehabilitation. Not to say that community safety was not a prominent feature of the data, but rather, more details were provided about the program components relating to accountability and rehabilitation. For example, community safety was assumed as the simple, clear, and basic premise that required little explanation because respondents used it as the building block from which all other comments flowed—it was readily apparent that a long discussion about the details or the importance of community safety was not required. That left time in the conversations for a rich and detailed exploration of the Phoenix Treatment Program.

Within the Accountability theme, several patterns were illuminated. One was the question of whether the Phoenix Treatment Program was truly "voluntary" as it is generally presented to eligible youth. Several JCs pointed out a potential contradiction--while the program is presented as "voluntary" (youth must assent/consent to the placement) that action initiates a court order that mandates successful completion of the program as probationary conditions. Additionally, if youth do not assent/consent to the placement, they will likely be subjected to a mandated placement in an Oregon Youth Authority (OYA) community-based treatment program located in another county. Thus, the Phoenix Treatment Program becomes a possible "last step" before escalating into OYA, which could facilitate a deeper enmeshment with the juvenile justice system, and if the youth continued their criminal behaviors, could result in an close-custody placement in an OYA youth correctional facility (YCF). In light of the potential severe consequences of refusing placement in the Phoenix Treatment Program, it can hardly be considered a voluntary placement. The other related pattern within Accountability was the understanding of the iatrogenic effects of the juvenile justice system. There were strong and consistent comments about the realization that the deeper a youth penetrates the system, the higher the likelihood of negative outcomes. This presented a tension within many of the JCs because they were trying to navigate the fine line between holding youth accountable for their crimes and the fear of pushing them deeper into a system that has demonstrated negative effects for youth.

There were many programmatic features and patterns under the theme of Rehabilitation. Perhaps the most common pattern was recognition that rehabilitation happens in context of healthy and positive relationships—that was the basic assumption voiced by many JCs about their experiences with the Phoenix Treatment Program. Beyond that there were five sub-patterns: Communication, Therapeutic Milieu, Trauma-Informed Treatment, Program Duration, Right Kid/Right Time. The Therapeutic Milieu contained three important components: gender-specific programs, shelter beds, and the point-level system. In addition, there were several suggestions for desired new program components to

consider. The five sub-patterns are explained below.

*Communication:* Not surprisingly, communication issues were prominent in the comments. More specifically, JCs wanted better communication between Phoenix Treatment Program staff, JCs, MLK staff, CFD Therapists and SUDS Counselors, youth and their families. There were several examples given that demonstrated where increased communication would have avoided frustrations stemming from misunderstandings and misplaced assumptions. Several respondents thought that co-locating the CFD therapists in the same building as the Phoenix Treatment Program would help communication, and also would provide opportunities for the Group Workers to work more closely with the CFD therapists in order to better integrate the treatment.

*Therapeutic Milieu:* The therapeutic milieu is a broad term used to describe the therapeutic environment that encourages healing by encouraging personal safety, community collaboration, and interpersonal relationships (Mahoney, Palyo, Napier, & Giordano, 2009). Ochoa (2012) described the therapeutic milieu in youth residential treatment as what happens during daily living activities that encompass the majority of time for youth in residential treatment. For example, formal counseling and therapy takes up a small percentage of time, while things like chores, group work, personal time, community outings, and school occupy the majority of time. The time outside of formal treatment is recognized as an important component of the overall treatment regime because the youth learn and practice skills in these informal blocks of time. Therapeutic milieu is closely related to increased engagement (the youth's willingness to engage with treatment) and has been identified as an important component to effective treatment programs (Huang, Duffee, Steinke, & Larkin, 2011). Engagement is related to therapeutic processes such as readiness to change, rapport, motivation, and working alliance (Horvath & Greenberg, 1994; Littell & Tajima, 2000; Prochaska & Diclemente, 1986).

*Gender-Specific Programs:* The JCs and the Mental Health Specialist identified gender-specific programs as something lacking in the Phoenix Treatment Program and there were significant concerns about the negative effects of placing girls in a co-ed program that is designed primarily to meet the needs of boys. It was pointed out that girls generally have different needs because they have different trauma histories and different criminal histories compared to boys (i.e. Zahn, Day, Mihalic, & Tichavsky, 2009; Matthews & Hubbard, 2008; OJJDP, 2010).

*Shelter Beds:* The conversation about shelter beds had two distinct components. One component was the recognition of a need for shelter beds in order to decrease the detention time for youth who have no other options. The other component was based in concerns about the possible disruption to the therapeutic milieu caused by the comings and goings of shelter youth who would not be official participants of the Phoenix Treatment Program but who would occupy the same spaces and interact with the Phoenix youth on a daily basis. Some of the JCs brought up concerns about the "contagion effect" which could be in play if higher risk shelter youth were grouped together with lower risk Phoenix youth. The risk levels of the shelter bed youth would need to be determined via the JCP Risk Assessment in order to understand which youth were high risk. The contagion effect has been well documented in the research and has informed best practices in juvenile justice for the past 20 years (Dishion, McCord, & Poulin, 1999; Lowenkamp & Latessa, 2004).

*The Point-Level System:* Many JCs were skeptical about the use of the point-level system in the program for several

reasons. The primary reason was that the point-level system doesn't translate well to skills needed for success outside of the program. The other reasons were that the JCs have direct experience with youth becoming overly focused on the point system instead of working to improve behaviors. There was recognition that program staff had not been trained on an alternative system of incentivizing positive behaviors and therefore the JCs understood why the system was being used in the program.

*Trauma Informed Treatment:* The need for trauma-informed treatments or at least the need to confirm the extent to which existing treatments were trauma-informed, was a prominent thread in the data. Several of the JCs who have worked in the field for decades commented that they noticed youth and families are more complex now compared to 10 or 20 years ago and that trauma is more prevalent now. Trauma is more of a common experience for youth who are considered for the Phoenix Treatment Program and therefore, treatments should be informed by evidence-based practices that recognize the effects of trauma on adolescent development. The desire to meet the needs of the youth in the program aligned well with the risk, needs, responsivity principle of criminal justice interventions (Gendreau, 1996).

*Program Duration:* There were many comments about the duration of the Phoenix Treatment Program and the fact that program duration has changed since the program's inception. There were also observations that the definition of official "graduation" from the program has changed. The JCs generally believe that the program duration has gradually decreased from its original six month requirement, to something like four months now. There were several reasons pointed out for this phenomenon, including the physical relocation of the program from the secure area to its current residential setting. JC's commented that when the program was in a secured locked environment, it was easier to keep youth for the required six month time. Now that the program is in a residential setting, youth can leave the program before completing the requirements because they have the freedom to walk out. The JCs were in strong agreement that they believe the program provides a healthier environment now that it is in a residential setting, because the program is in compliance with BRS rules.

There was also a strong thread in the data indicating that "completion plans" might be a better way to conceptualize success in the program (opposed to "graduation plans"), and completion plans should be individualized for each youth depending on their risks and needs. There was concern that some youth do not technically "graduate" from the program (even though they made significant personal progress and positive growth) and the "non-graduation" is sometimes viewed by the court as a failure. Some youth might benefit from being in the program for six months, others might benefit from a shorter time. There was a general sense that about four months duration was the "sweet spot"—after four months, many JCs reported that their youth in the program tended to either slow their progress, or regress into negative behaviors. While there were no clear reasons given for why progress typically begins to erode after four months, many JCs speculated that the daily stressors of living in close quarters with other behaviorally challenged youth might relate to some sort of "burn out" from the program.

*Right Kid/Right Time:* This was a clearly established pattern in the data. The idea of Right Kid/Right Time refers to the Risk/Need/Responsivity (RNR) framework that informs criminal justice interventions (Gendreau, 1996). The JCs spoke of this in a variety of ways that illustrated their professional challenges of addressing

treatment decisions based on the RNR model while at the same time applying their own professional expertise in making a recommendation to place a youth in the Phoenix

| Juvenile Court Counselors (JCCs)<br>Summary of Prominent Themes and Patterns |
|---|
| Themes: |
| • Community Safety<br>• Accountability<br>• Rehabilitation |
| Patterns within Prominent Themes: |
| • Phoenix Treatment Program isn't really "voluntary"<br>• The juvenile justice system can have unintended negative effects on youth<br>• Don't want to push a youth deeper into the system<br>• Rehabilitation takes place in the context of healthy relationships<br>• Communication<br>• Therapeutic milieu<br>• Trauma-informed treatment<br>• Program duration<br>• Right Kid/Right Time<br>• Gender-specific programs<br>• Shelter beds<br>• Point-level system |

Treatment Program. That is, the decision to place a youth in the program was informed by the RNR model and also considerations about what the JCs believed was best for the youth (based on the JCs' professional expertise). In this way, the JCs utilized the human services approach to decision-making as advocated by Latessa and Lowenkamp (2006). The JCs' application of professional expertise also conforms to the evidence-based framework first proposed by Sackett, et al. (1996) that has three components: current best evidence of what is effective, practitioner expertise and professional judgement, and what the client needs. JCs explained that before recommending a youth for placement in the Phoenix Treatment Program, they will consider the youth's behavior, underlying problems, family functioning and support (including the ability/availability of the family to participate in the treatment), criminal history, risk level, youth needs, youth age, youth gender, and a variety of other considerations that fall into the category of "practitioner expertise and professional judgement." These considerations included how the newly referred youth might get along with youth currently in the program. For placement of girls, JCs considered if there were other girls currently in the program—and if not, many JCs would lean away from making a referral for a lone girl because of concerns of how the boys in the program would treat her.

*Desired New Program Components:* There were three new program components that emerged from the data. One was to provide increased support and training for program staff on issue of evidence-based practices, including trauma-informed residential treatment services. Another was to provide a more robust after-care treatment regime for youth and families. Finally, suggestions for a parent support group were included in the data. The parent support group would be an opportunity for parents to learn from each other, find out what other parents were struggling with, or what successes they had, and generally create a supportive group environment that would create a sense of community for the parents who had youth in the Phoenix Treatment Program.

## CONTRACTED TREATMENT PROVIDERS

Lane County Youth Services contracts with Center for Family Development (CFD) to provide behavioral rehabilitation services (BRS) for the Phoenix Treatment

Program. CFD participated in the initial conversations that led to the creation of the program in the early 2000's, and they have been the contracted treatment provider since then. The contracted services include mental health therapists, treatment coordination, SUDS counseling, and supervision.

*Prominent themes and Patterns:* Three prominent themes were contained in the data from the contracted treatment providers: Communication, Program Goals, and Treatment Framework. Within each theme, the data revealed several patterns that emerged.

*Communication:* There was a clear understanding that increased effective communication between youth, families, Phoenix Program staff, and treatment providers was a critical component of positive outcomes for youth. Many respondents mentioned challenges with communication—not stemming from any Machiavellian efforts to subvert communication—but rather, resulting from the fact that all parties involved in the program have busy schedules that often make it difficult to schedule a time to communicate. There were important patterns within the communication theme that bear mention. One was regarding how the Phoenix Treatment Program is communicated to youth and families who are in the process of referral. Key respondents highlighted the need for Lane County Youth Services staff and contracted treatment providers to communicate openly and completely with youth and families regarding the potential risks and potential benefits of participating in the program. The consequences of successful completion, as well as the consequences of non-completion, are vitally important features of the conversations that take place with youth and families when they are being considered for the Phoenix Treatment Program. There was consistent agreement that physically housing the contracted treatment providers in the same building as the program would help facilitate communication because of increased physical and temporal proximity to the program.

There were a few observations regarding how challenging it is to schedule time to meet with families because of busy schedules, separated or divorced parents living in different households, and the sheer level of intrusiveness that comes with having a youth involved in the juvenile justice system. For some low functioning families with few resources, the multiple demands from "the system" can be daunting at best, and at worst threatening.

| Contacted Treatment Providers<br>Summary of Prominent Themes and Patterns |
|---|
| Themes: |
| • Communication<br>• Program Goals<br>• Treatment Framework |
| Patterns within Prominent Themes: |
| • Increase communication between all parties<br>• Increased communication to youth and familes about the benefits of successful completion and consequences of non-completion<br>• Program "drift"<br>• Concerns about the Point-level system<br>• Phoenix staff support and training<br>• Fidelity to treatment model |

*Program Goals:* There is overwhelming agreement that the Phoenix Treatment Program is intended to be a strength-based therapeutic program that provides youth and families with skills to live healthy and successful lives outside of the program. The program's therapeutic model

includes a resiliency interview at the start of treatment to identify youth strengths, and then provides an evidence-based treatment regime that is headlined with trauma-based cognitive behavioral therapy. That said, there were concerns of "program drift" over the years resulting from personnel changes and decreased fidelity to the program model. Along those lines, there were concerns that there has been a move away from the goal of success outside of the program; with the example given that Community Visits (CVs) should not be used as a "reward" for good behavior in the program. Instead, CVs should be used as opportunities for youth and families to practice their newly acquired skills in real life settings, and that feedback from the CVs should be used to inform the therapeutic process and to measure progress in the program. There were other concerns about the relatively low dosage of the treatment that attempted to ameliorate years of previous unhealthy family functioning, drug and alcohol abuse, negative peer influences, and criminal behaviors.

*Point-level System:* The point-level system was predominant in the data, and there were substantial concerns that the point-level system does not facilitate skill attainment needed for successful living outside of the program. The potential subjectivity of the point-level system administration was pointed out, as was the potential delayed feedback to youth caused by program staff shift changes. There was also concern and understanding for the Phoenix Treatment Program staff and their need for practices and methods to manage youth behaviors in the program, as well as the need to somehow measure youth progress in the program.

*Treatment Framework:* The Phoenix Treatment Program model is an evidence-based therapeutic program that delivers strength-based treatment under the umbrella of trauma-informed cognitive behavioral therapy. Within that umbrella, a number of other treatment modalities including Motivational Interviewing, Contextual Family Therapy, Trauma-informed Therapy, and Circular Questioning are utilized. While there was strong agreement of the treatment model, there was no evidence of fidelity of implementation processes that provided quality control, or a "check-up" to determine if in fact the therapies were delivered according to the models. Additionally, there was a consistent pattern of recognizing the need to support and train Phoenix Treatment Program Group Worker in best practices for residential treatment programs for youth involved in the juvenile justice system. There was a suggestion to consider recalibrating Group Worker jobs to include more of a mental health counseling model that includes trauma-informed treatment approaches.

| **MLK Education Center Personnel**<br>**Summary of Prominent Themes and Patterns** |
|---|
| Themes: |
| • Communication<br>• Alternative Education |
| Patterns within Prominent Themes: |
| • Increase communication with Phoenix staff<br>• High levels of communication exist amongst MLK staff<br>• Alternative education best practices: teaching methods, modified curricula, hands-on learning, caring and empathetic teachers<br>• Academic credit for Phoenix group work?<br>• Residential setting is better |

## MARTIN LUTHER KING JR. EDUCATION CENTER PERSONNEL

Three Martin Luther King Jr. (MLK) Education Center personnel were interviewed for the evaluation, including two classroom teachers and the Director.

*Prominent themes and Patterns:* The data from the MLK personnel contained two themes: Communication and Alternative Education, and there were distinct patterns within each theme.

*Communication:* The issue of communication was highlighted again in this group, but in contrast with other interview respondents, this group included both negative and positive comments. For example, there was recognition that communication between MLK personnel and Phoenix Treatment Program personnel could be improved, although there was daily communication about youths' points and grades. There were also positive comments about the level of communication and collaboration amongst MLK personnel.

*Alternative Education:* Respondents indicated that their practices align with best practices in alternative education by highlighting changing their teaching methods according to the wide range of academic abilities found within their classrooms, modifying the curricula to include hands-on and real-life examples to increase student engagement, and deploying a caring and empathetic teaching staff. Alternate education is sometimes characterized by allowing academic credit for non-school work, and the MLK personnel asked the question if it made sense to grant academic credit to Phoenix Treatment Program youth for some of their group work completed in the program. Finally, respondents mentioned the more positive educational milieu that resulted in the Phoenix Treatment Program moving from the secure space to the residential space.

## LANE COUNTY CIRCUIT (JUVENILE) COURT JUDGES

Two Circuit Court judges were interviewed for this evaluation. One was the sitting Juvenile Court at the time of the evaluation and the other was a former Circuit Court judge who sat on the Juvenile Court during the time the Phoenix Treatment Program started operating.

*Prominent themes and Patterns:* Both judges' comments touch on the theme of rehabilitation and the founding principle of the juvenile justice system that is based on the premise that because of their immaturity, youth accused of a crime should be treated differently than adults (Bernstein, 2014; Feld, 2017; National Research Council, 2013). Neither judge spoke to the developmental processes that propel many youth into the juvenile justice system, a process that is often characterized by low family functioning, violence, victimization, drug and alcohol abuse, and negative peer relationships.

| Juvenile Court Judges<br>Summary of Prominent Themes and Patterns |
|---|
| Themes: |
| • Rehabilitation |
| Patterns within Prominent Themes: |
| • Adolescents should not be treated merely as little adults--they are fundamentally different |

## DISCUSSION: EXPERIENCES OF LANE COUNTY STAFF AND TREATMENT PROVIDERS

The purpose of this section is to provide the reader with a synthesis of the results from the six work groups that were represented in the interviews. The limitations to the analysis, as well as an explanation of the qualitative data analyses are explained. A discussion about the results is provided, as well as suggestions for determining substantive significance. Finally, implications of the results are discussed.

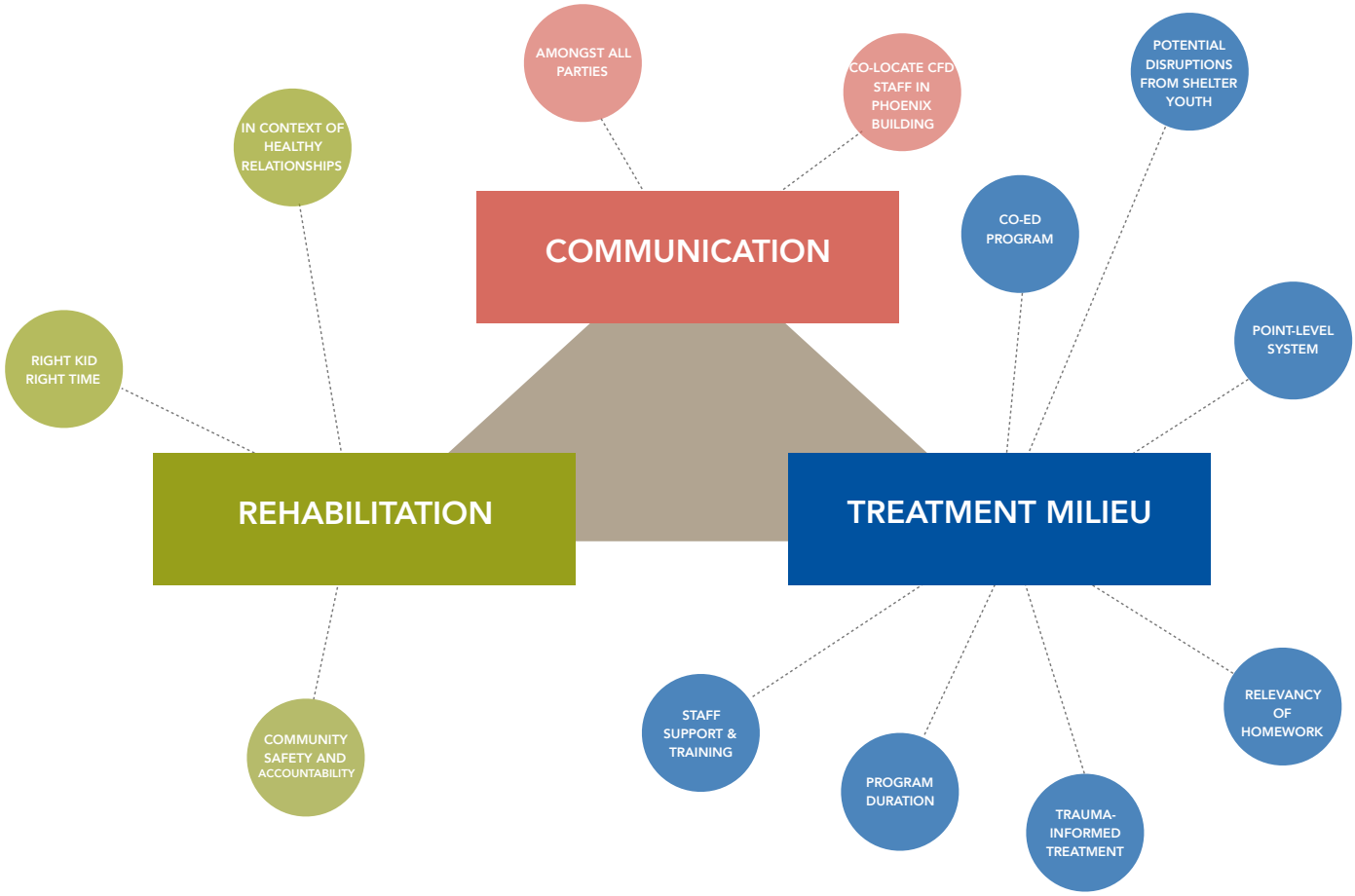
*Limitations:* As with other parts of the Phoenix Treatment Program evaluation, this portion of the evaluation has several limitations that should be recognized before any conclusions are made about the results. First, the interviews were incomplete. There are likely two reasons for this. The first reason is while the evaluator made efforts to make sure all Phoenix Treatment Program staff and all contracted treatment providers were aware of their opportunity to participate in the interviews, it is possible that some people didn't hear about it. The second reason is that even though people heard about the opportunity to participate in the interviews, they might have chosen not to participate. There are many possible reasons why people chose not to participate, including not being interested in the evaluation, not wanting to invest the time to meet with the evaluator, not having the time to meet with the evaluator, not trusting the evaluator to maintain anonymity, thinking that the evaluation was a waste of time, or not wanting to disclose information to the evaluator. Whatever the reasons, the fact was that the interviews were incomplete (not all Phoenix Treatment Program staff or contracted treatment providers were interviewed) and it is likely that important voices were left out of the data collection process. For example, several long-term Phoenix staff declined to be interviewed, and as a result, their experienced perspectives were not included.

The 37 people that were interviewed did so voluntarily, and it is possible that their volunteer status skewed their answers to the interview questions. Also, the evaluator could have inadvertently steered the interview questions into areas and topics that were of interest to the evaluator and not the interviewee.

Finally, qualitative analysis is an abstract process filled with potential biases that stem from the evaluator's experience and ability to mold interviews, observations, documents, and field notes into a useable report. Patton (2002) noted "The challenge of qualitative analysis requires making sense of massive amounts of data. This involves reducing the volume of raw information, sifting trivia from significance, identifying significant patterns, and constructing the framework for communicating the essence of what the data reveal" (p. 432). Along that pathway of making sense of the qualitative data, there were many opportunities for missteps in the analyses. In the efforts to uncover consistent themes and patterns in the qualitative data, the evaluator used his 20 years of professional experience with the juvenile justice system in general, and specifically with Lane County Youth Services, to make judgements in how to report the findings. Certainly in that process, subjectivity played a role.

Despite the limitations noted, the results from the interviews with Lane County staff and contracted treatment providers delivered useful information that can be used to deepen the understanding about the Phoenix Treatment Program processes and point the way towards possible changes in the program to increase its effectiveness and improve outcomes for youth and families.

## SUMMARY OF QUALITATIVE RESULTS




*Wide Representation:* The 37 people interviewed for this portion of the evaluation represented six different work groups: Program Directors, Group Workers and Program Supervisors, JCs and Mental Health Specialist II, Center for Family Development contracted treatment providers, Martin Luther King Jr. Education Center staff, and Lane County Circuit Court judges. In this regard, the respondents represented all of the primary work groups that interact with the Phoenix Treatment Program on a daily basis, and therefore provided a reasonable sample.

*Qualitative Process:* In developing the themes and patterns in the data, the evaluator employed a two-step analysis: convergence and divergence (Guba, 1978). The convergence activities included figuring out what items fit together with reoccurring regularity. The regularities illuminated patterns that were sorted into categories. The evaluator used both "analyst-constructed" typologies and "theory-based" typologies to categorize the data. The analyst-constructed typologies were created from the participants' responses, and the theory-based typologies were identified from the academic literature regarding the philosophical underpinnings of the juvenile court (Community Safety, Accountability, and Rehabilitation). These categories were judged using two criteria: internal homogeneity and external heterogeneity (Patton, 2002). Internal homogeneity is how well the data fit together in logical and meaningful ways, and external homogeneity is the extent to which the differences between the categories

are distinctly clear.

## MAJOR THEMES AND PATTERNS

*Rehabilitation:* The dominant explicit theme was Rehabilitation, and the clear understanding that rehabilitation takes place in context of healthy therapeutic relationships. The rehabilitation theme was most prominent in responses from the Program Supervisors, Group Workers and Program Supervisors, JCs and Mental Health Specialist II, and the Judges. The rehabilitation theme mapped directly onto the theory-based typology of the juvenile justice system that also includes Community Safety and Accountability (Bilchik, 1998; National Research Council, 2013). In addition, the judges highlighted the principle that youth in the juvenile justice system should be treated differently than adults. This aligned well with best practices that recognize the relationships between adolescent brain development and impulsivity, risky behaviors, and lack of decision-making skills (American Academy of Child and Adolescent Psychiatry, 2016; Coalition for Juvenile Justice, 2006)

*RightKid Right Time:* Within the Rehabilitation theme, there was a strong pattern of what respondents called "Right Kid, Right Time, Right Program" which referred to the subjective process of deciding which youth would be a good fit for the Phoenix Treatment Program. The "Right Kid, Right Time, Right Program" pattern maps strongly onto the best practice in juvenile justice in which style and mode of interventions are matched to the youths' learning styles and abilities (Andrews, Bonta, & Wormith, 2011).

*Community Safety and Accountability:* There were implicit themes of Community Safety and Accountability woven into most of the respondents' answers to the interview questions. For example, most respondents implied they understood Community Safety was the ultimate criterion for making decisions about youth referrals into the program, youth progress and continuation in the program, youth completion/graduation from the program, and termination from the program. The JCs spoke directly about Accountability and their struggles to communicate with youth and families about the Phoenix Treatment Program, and the challenges of describing the program as "voluntary" when in fact; it probably isn't voluntary in the true sense of the word. The JCs were keenly aware of possible iatrogenic effects of pushing youth deeper into the juvenile justice system.

*Treatment Milieu:* Treatment Milieu was another prominent theme. Treatment Milieu (also referred to as *Therapeutic Milieu*) is described in the literature as the consistent plan of care that encompasses round-the-clock supervision (Leichtman, 2006). Treatment Milieu is an important component of effective residential treatment because it recognizes that while formal therapy and counseling services are impactful, more impact and effects happens from the daily living activities and tasks that the youth complete as part of their routines. More time is spent on things like chores, homework, group work, personal time, eating, school, and community outings than is spent in formal therapy sessions (Ochoa, 2012). Huang, Duffee, Steinke, and Larkin (2011) described the Treatment Milieu as an integral part of the theory-of-change for residential treatment in which the Treatment Milieu provides a culture of change for youth. Not surprisingly, Group Workers mentioned the importance of the Treatment Milieu in their work. This makes sense because the Group Workers spend the most face-to-face time with the youth in the Phoenix Treatment Program and it is logical that they would recognize the value of maintaining a healthy and healing environment.

There were many patterns within the Treatment Milieu

theme that bear mentioning: challenges in maintaining a co-ed program, potential disruptions from "shelter" youth, the point-level system, program homework perceived as "busy-work", staff support and training, program duration, and trauma-informed treatment methods. The concerns about the potential disruptions of the Treatment Milieu caused by shelter youth were based on three things: natural disruptions caused by new youth coming and going, disruptions caused by shelter youth living in the same space but not required to participate or complete the treatment components of the Phoenix Treatment, and potential disruptions/negative outcomes resulting from mixing shelter youth with Phoenix youth. The CFD treatment providers mentioned concerns about fidelity to the treatment model.

*Communication:* Communication was closely related to the Treatment Milieu and was deeply intertwined with the desire to create and maintain a healthy healing environment. There were numerous patterns within the Communication theme including: better communication between Youth, Families, Group Workers, CFD treatment providers, JCs, and the Court; co-locating CFD treatment providers within the Phoenix Treatment Program building. The importance of effective communication is a dominant theme in the academic literature, and it is particularly necessary in residential treatment programs, where numerous staff members are required to coordinate numerous small decisions during the course of a day. A horizontal communication structure is required within the program (logs, meetings, informal contact) (Leichtman, 2006), but a vertical communication structure is also required in order to communicate effectively with other treatment personnel (in this case, CFD treatment providers, JCs, MLK personnel, and the Court). In this way, communication in and around the Phoenix Treatment Program is particularly challenging. It is interesting to note that while Communication was identified as an important feature, not all of the respondents mentioned it. For example, the Program Supervisors and the Judges did not highlight Communication as a prominent theme.

## SUBSTANTIVE SIGNIFICANCE

Qualitative findings do not have statistical significance as qualitative findings have—therefore it is important for the reader to consider other ways of determining their own value judgements about significance. Patton (2002) suggested the following four points:

- How solid, coherent, and consistent is the evidence in support of the findings?
- To what extent and in what ways do the findings increase and deepen understanding of the phenomenon?
- To what extent are the findings consistent with other knowledge?
- To what extent are the findings useful?

## IMPLICATIONS

There are four implications to consider for the Phoenix Treatment Program that emerged from the synthesis of the qualitative data.

*Strong Professional Dedication:* One implication flows from the vibrant organizational culture of dedication and professionalism towards the goal of helping youth to develop prosocial skills so they can live healthy and successful lives outside of the Phoenix Treatment Program. The moral and ethical value of supporting youth from a strength-based perspective was well documented in the data, and this will help guide the Phoenix Treatment Program as it continuously adjusts its program delivery to align with best practices. In other words, the professionals

## IMPLICATIONS OF QUALITATIVE DATA ANALYSIS

**STRONG PROFESSIONAL DEDICATION TO HELPING YOUTH: The staff and treatment providers demonstrated a deep level of committment to helping youth and families. This will serve as the underlying force to help guide the Phoenix Treatment Program as it continuously adjusts towards best practices**

**REHABILITATION TAKES PLACE IN CONTEXT OF HEALTHY RELATIONSHIPS: There was a strong recognition of the critical role that healthy relationships play in rehabilitiation. This will continue to be a fundamental component in aspects of the Phoenix Treatment Program. Group Worker support and training in trauma-informed treatments will be important**

**IMPORTANCE OF TREATMENT MILIEU: This is closely related to healthy relationships, with the added factor of group dynamics. The treatment milieu is an important component to consider for any decision regarding the Phoenix Treatment Program. Treatment milieu also includes the idea of "legitimacy" and decisions about program curricula should consider legitimacy**

**EFFECTIVE COMMUNICATION: The need for clear, consistent and professional communication was strongly voiced, and this should guide changes in how to address the sizeable challenges of communicating within a complex organization, with many different people (including youth and families) in different physical locations, across multiple job shifts**

that interacted with the youth and families were heavily invested in helping their clients, and this will be a stabilizing force as the program moves forward.

*Rehabilitation Takes Place in Context of Relationships:* The second implication stems from the recognition that rehabilitation takes place in the context of healthy relationships. This is particularly relevant for Group Workers who spend the most time with the youth in the Phoenix Treatment program day in and day out. Recognizing the critical importance of positive and therapeutic relationships implies the relevancy of supporting Group Workers with not only shift-level actions (increased communication, work load, supervision support) but also professional support such as trauma-informed training and continuing professional education opportunities.

*Importance of Treatment Milieu:* The third implication is about creating and maintaining the Treatment Milieu, which has multiple parts. Perhaps the most striking implications have to do with examining the validity of the point-level system, the potential disruptions caused by the introduction of "shelter" youth into the program, and the challenges of operating a co-ed residential treatment center. Maintaining a healthy treatment milieu also implies the importance of carefully considering placement decisions into the Phoenix Treatment Program.

*Communication:* The fourth implication is specifically about effective communication and the challenges that exist in a very complex organization with many different people in many different physical locations.

7

# BENEFIT-COST ANALYSIS

**A TRUE BENEFIT-COST ANALYSIS OF CRIME PREVENTION PROGRAMS IS DIFFICULT BECAUSE OF THE CHALLENGES IN ASSIGNING MONETARY VALUES TO THE BENEFITS OF THE PROGRAM. FOR THIS EVALUATION A SIMPLIFIED "BREAK-EVEN" ANALYSIS WAS PERFORMED TO DETERMINE IF THE PHOENIX TREATMENT PROGRAM INITIAL COSTS WERE OFFSET BY POTENTIAL SAVINGS CAUSED BY LOWER RECIDIVISM. THE RESULTS OF THE BREAK-EVEN ANALYSIS SHOWED THAT EVEN THOUGH THE PHOENIX TREATMENT PROGRAM COSTS ABOUT $73,000 PER YOUTH, THE COSTS ARE MORE THAN OFFSET BY FUTURE SAVINGS DUE TO REDUCED CRIME**

The basic premise of a benefit-cost analysis is simple: compare the monetary benefits of a program with its monetary costs—if the benefits outweigh the costs that would be an indication the program was delivering results in an economically beneficial manner. If the costs outweigh the benefits that would indicate the program was not delivering its outcomes in an economically beneficial manner. Benefit-cost analyses are particularly noteworthy for governmental programs because they suggest a way to calculate society's overall benefits of a particular program (National Research Council, 2013). In other words, benefit-cost analyses provide information regarding the full cost of programs and compare those costs with the dollar value of all the program benefits (Wholey, Hatry, & Newcomer, 2004).

The easier task in benefit-cost analyses is quantifying program costs. The much more difficult task is monetizing all the program future benefits because of the subjectivity involved in deciding if something is truly a benefit, and then assigning a dollar figure to that benefit (Aos, 2015). It is also difficult to assign monetary values to future societal costs, such as costs associated with fear of crime, and costs associated with avoidance behaviors (e.g. installing an alarm).

In the juvenile justice field, benefit-cost analyses are particularly important for the general tax-paying public because they add evidence to whether a particular crime prevention program "works" or not. Benefit-cost analyses are also important for policy-makers, decision-makers, and elected officials who must make program funding decisions within a finite budget—that is, benefit-cost analyses can contribute decisions on whether to start a new program, or to continue funding an existing program. With all of the scrutiny placed on program funding, it would be reasonable to assume there was an agreed upon method of conducting benefit-cost analyses. But that would be an incorrect assumption because there is little agreement regarding the procedures to use in performing a benefit-cost analysis (National Research Council, 2013).

Wickramasekera, Wright, Elsey, Murray, and Tubeuf (2015) proposed the following framework in which crime costs can be categorized into three components:

*Direct costs:* the consequences of crime that have an actual monetary exchange involved, such as police or court costs

*Indirect costs:* the economic value stemming from the consequences of a crime such as a victim's lost production time, or negative health effects flowing from being a victim of a crime

*Intangible costs:* the economic value of effects incurred by victims, potential victims, and society in general. They include results such as fear, pain and suffering, and loss of quality of life

*Challenges:* One significant challenge with measuring both the direct and indirect costs of crime is that there are many different types of crime, with many different magnitudes of costs associated with them (National Research Council, 2013). Obviously, a low-level crime such as Criminal Mischief would have much lower costs compared to a violent crime such as Murder. Another factor to consider is the timing of costs associated with a crime. Some costs are incurred in anticipation of a similar crime happening again, some are realized as a direct result of a crime, and still others result from responses to a crime that has already happened (U.S. Government Accountability Office, 2017).

*Different Perspectives:* Wickramasekera, et al. (2015) also suggested all of the above costs could be measured from three different perspectives: costs from a victim's perspective, costs from a government perspective, and costs from a societal perspective.

Another helpful way to think about benefit-cost analyses in the context of juvenile justice is to study the benefits and costs associated with programs designed to reduce crime. The Phoenix Treatment Program is one of those programs, and therefore, it is prudent to investigate its benefit cost ratio. While completing the benefit-cost analysis, it is important to acknowledge the sizable uncertainty that exists with the technique (Aos, 2015).

## METHOD

Utilizing the typology from Wickramasekera, et al. (2015) and from the United States Government Accountability Office (2017), the following benefit-cost schematic was developed:

The Juvenile Justice Information System (JJIS) was searched to determine the number of youth who participated in the Phoenix Treatment Program during the years 2014 through April 2019. In order to align the data with fiscal year instead of calendar year, the JJIS information was exported to an Excel spreadsheet and the number of youth who participated for each fiscal year was calculated.

For the purpose of simplicity, the evaluator chose to only examine the tangible direct costs of the police, the juvenile court, and Lane County Youth Services (intake, case management, detention, etc). It was recognized that this pared-down benefit-cost analysis did not provide a complete accounting, and likely greatly understated the indirect and intangible costs that would result from future crimes. An in depth analysis of the indirect and intangible costs were outside the scope of this program evaluation.

## TABLE 7: COST OF CRIME TYPOLOGY

| | Cost of Crime | | |
|---|---|---|---|
| Tangible: | Examples of Costs in Anticipation of a crime | Examples of Costs as a direct consequence of a crime | Examples of Costs in response to a crime |
| Direct | Expenditures to reduce the likelihood of victimization (i.e. purchasing a security system)<br><br>Crime Prevention programs | Victim's lost wages<br><br>Victims' medical expenses<br><br>Victims' property loss | Police<br><br>Juvenile Court<br><br>Lane County Youth Services (intake, case management, Phoenix Treatment Program, detention, etc.) |
| Indirect | Insurance costs | Cost to society for recovery of lost property<br><br>Employers' lost productivity | Society's future lost productivity<br><br>Offender's future lost productivity |
| Intangible: | Avoidance behavior<br><br>Fear | Victim Pain & suffering<br><br>Family of victim pain & Suffering | Victim's family health outcomes<br><br>Offender's family health outcomes<br><br>Societal overdeterrence costs (i.e. restriction of community's legitimate activities) |

## RESULTS

Phoenix Treatment Program Revenues and Costs: The Lane County Youth Services Senior Accounting staff supplied the following revenues and costs for fiscal year 2018-19:

Total Revenues $2,495,968: General fund transfer $1,450,931 (58.2%); Property tax $712,232 (28.5%); Title XIX (Medicaid) $219,750 (8.8%), Food & Nutrition $113,055 (4.5%).

Total Costs $2,495,968: Personnel $1,976,932 (79.2%); Materials & Services $485,651 (22.2%); Other Expenditures $33,386 (1.3%). There were 16.61 Full Time Equivalent (FTE) employees associated with the Phoenix Treatment Program in fiscal year 2018-19.

*Cost per Youth in Phoenix Treatment Program:* An analysis of the number of youth who participated in the Phoenix Treatment Program yielded the following information:

Fiscal Year 2014/15 32 youth

Fiscal Year 2015/16 36 youth

Fiscal Year 2016/17 29 youth

Fiscal Year 2017/18 35 youth

Fiscal Year 2018/19 39 youth*

*JJIS included 11 months data which were extrapolated to include 12 months

The average number of youth who participated in the Phoenix Treatment Program was 34.2 for the five fiscal year periods 2014 through 2019.

Program Cost per youth: $2,583,469 ÷ 34.2 youth = $72,981.52

For estimation purposes, round up to $73,000 per youth.

*Direct Costs in Response to a New Crime:* There are three major direct cost components associated with a new referral--police, youth services, and the court. The Eugene Police Department analyzed costs associated with the police response for the number of youth ages 14 - 17 who ran away more than one time during 2018. Based on their analysis, the average cost per hour was $69.63 (full benefits).

The circuit court analyzed their costs associated with a Judicial Services Specialist, a Judicial Clerk, and a Judge, and calculated the total cost per hour was $175.46 (full benefits).

A review of the Lane County Youth Services salaries and benefits found that the combined costs for a Senior Juvenile Counselor and a Juvenile Counselor 1 (both Step 6) was $102.09/ hour (full benefits).

*Assumptions used in Benefit-Cost calculation:*

1. Based on 2017 data, youth who participated in the Phoenix Treatment Program recidivated 0.3 referrals less than youth who did not participate in the Phoenix Treatment Program. In 2017, the average new referrals for Phoenix Treatment Program youth was 0.4, and the average new referrals for non Phoenix youth was 0.7.

THE PHOENIX TREATMENT PROGRAM COSTS ABOUT $73,000 PER YOUTH

2. Only the Direct Costs in Response to Crime (2019 dollars) were used. The following assumptions were made:

Each new referral generates

| | |
|---|---|
| Police 2 hours x $69.63/hour = | $139.26 |
| Youth Services 2 hours x $102.09/hour = | $204.18 |
| Court Costs 2 hours x $175.46/hour = | $350.92 |
| Deputy District Attorney | |
| 2 hours x $100.55/hour = | $201.11 |
| Total costs per new referral = | $895.47 |

Apply the new referral "savings" associated with the Phoenix Treatment Program lower recidivism rate compared to youth who did not participate in the Phoenix Treatment Program: 0.7 referrals - 0.4 referrals = 0.3 referrals

| | |
|---|---|
| 0.3 x $895.47 = | $268.64 |
| For estimation purposes, round up to | $270.00 |

*Modeling the Tangible and Intangible Costs of a New Crime:* There are a number of ways to estimate the tangible and intangible costs associated with a new crime. The Washington State Institute for Public Policy (WSIPP) assembled what is probably best practices for creating a benefit-cost model in their publication "Benefit-Cost Technical Documentation" (2018), and many governmental jurisdictions have patterned their benefit-cost analyses on the WSIPP template. One of the unique features of the WSIPP model is a technique to monetize the effects of new crimes that includes an in-depth examinations of different criminal patterns for selected

THE PHOENIX TREATMENT PROGRAM IS FUNDED WITH A COMBINATION OF GENERAL FUND TAX DOLLARS, LOCAL OPTION TAX LEVY, AND MEDICAID.

THE TOTAL YEARLY BUDGET WAS $2,495,968 IN FISCAL YEAR 2018-19

populations, criminal justice system probability and length of resource use, the number of victims per crime, and the costs per new crime for the criminal justice system and victims (Washington State Institute for Public Policy, 2018).

Such an in-depth approach to calculating a benefit-cost ratio for the Phoenix Treatment Program was outside of the scope of the evaluation, and therefore, a simplified approach was utilized that provided a reasonably conservative estimate and academically defensible analysis of the benefits of the program. The calculation used a simulated net present value exercise that examined two time frames in order to determine the annual "savings" that would have to occur in order to "break even" with the Phoenix Treatment Program costs.

The process identified the tangible and direct costs associated with a new crime, which corresponds to the upper right hand cell in Table 7. All of the other cells in Table 7 were represented by the letter "A" in the following equation. Two time frames were used to provide an estimate into how many years the costs represented by "A" in the equation would play out. For example, how long should "insurance costs" be amortized? Do the increased costs of purchasing insurance against loss due to crime take place over one year, two years, five years, or ten years?

Likewise for intangible costs such as fear, or avoidance behavior, as well as victim pain and suffering, etc. The literature on this subject does not provide clear direction, and it is easy to understand why there is a sizable amount of educated guessing that takes place in these kinds of economic analyses.

For purposes of this evaluation, the approach was simplified to "How much would all of the costs (except the tangible direct costs in response to a new crime) have to equal in order to break even with the costs of the Phoenix Treatment Program for one youth?"

$$A = \frac{i\,(NPV)}{1 - (1 + i)^{-n}}$$

The following variables were used:

A = yearly costs, assumed to occur once at the beginning of the year;

i = yearly interest rate;

n = years;

NPV = net present value of cash flows;

X = sum of all of the tangible and intangible costs of crime - tangible direct costs associated with the response to a new crime.

The "break even" number was the total cost per youth in the Phoenix Treatment Program as previously calculated $76,000, minus the tangible direct costs in response to a crime $270: $73,000 - $270 = $72,730.

The following equation was used to calculate the yearly amortized "payments" that would equal the net present value of $72,730:

A yearly interest rate of 3% was assumed.

For the first calculation, a five year time period was assumed, and therefore the values for the equation variables were:

*i* = 3%

NPV = $72,730

n = 5

Substituting these values into the equation yielded

A = $15,418

For the second calculation, a ten year time period was assumed, and therefore the values for the equation variables were:

*i* = 3%

NPV = $72,730

Substituting these values into the equation yielded

A = $8,278

## DISCUSSION

This was an economic analysis designed to examine the benefit-cost ratio of the Phoenix Treatment Program. Several limitations should be considered before arriving at any conclusions regarding the benefit-cost ratio of the program. There were many assumptions made in this analysis which might not be accurate. The analysis was framed using Wickramasekera et al. (2015) and the United States Government Accountability Office (2017). This approach was vastly more simple than the recognized state of the art approach used by the Washington State Institute for Public Policy (2018) and it is possible that the simplified approach used in this analysis simply was inadequate to flesh out the benefit-cost ratio for the Phoenix Treatment Program.

It is also recognized that the analysis was not purely a benefit-cost analysis because the benefits of the Phoenix Treatment Program were assumed to only include less recidivism compared to non-Phoenix program recidivism. There are likely many other benefits to the Phoenix Treatment Program that are significant to not only the youth who participated in the program, but also to their families and communities. For example, other crime prevention programs have recognized benefits such as increased school engagement and achievement, increased employment, and increased physical and mental health outcomes. These potentially significant benefits were not included in the analysis.

The actual costs associated with the response to a new crime were based on conversations with Lane County Youth Services staff, Eugene Police, and the Juvenile Court. A middle of the road estimate was used--that is, it was recognized that misdemeanor crimes typically require less system response than felony crimes, and the time estimate was for a high level misdemeanor or low level felony crime. It is possible that the time estimates and the associated costs were not accurate.

Finally, the recidivism rates for the Phoenix Treatment Program youth and the non-Phoenix Treatment Program youth were from 2017, and the costs per new crimes were calculated for fiscal year 2018-19. Because of the year mismatch, there was likely a small amount of error in the cost calculation.

That said, the benefit-cost analysis yielded useful

A SIMPLIFIED BREAK-EVEN ANALYSIS DEMONSTRATED THAT THE PHOENIX TREATMENT PROGRAM PROVIDED GOOD VALUE TO THE TAXPAYERS OF LANE COUNTY

information. The nine different types of costs associated with a new crime shown in Table 7 provided a simplified conceptual total cost model to consider. The basic premise was "what is the monetary value of everything in Table 7, with the exception of the costs in response to a new crime?" This approach allowed the use of a net present value calculation that assumed the cost per youth of the Phoenix Treatment Program as the break-even figure. Subsequently, a yearly amortized amount was calculated using a conservative yearly interest of 3%. Two time frames were used as a way to establish possible ways of looking at the effects of time on the break even analysis. A five year amortization yielded a yearly "payment" of $15,418 and a ten year amortization yielded a yearly "payment" of $8,278. These "payments" represent a value by which to compare against the summation of all of the costs in Table 7, minus the tangible direct costs associated with a response to a new crime (Police, Lane County Youth Services, Juvenile Court)

Another way to think about these results is with the question "Do all of the costs (tangible direct, tangible indirect, and intangible) represented in Table 7 (except for the tangible direct costs associated with the response to a new crime) add up to $8,278 per year (for a ten year time period), or $15,418 (for a five year time period)?"

It is not unreasonable to assume that the intangible costs (avoidance behavior, fear, victim pain and suffering, family of victim pain and suffering) alone are more than $8,278 per year (five year timeline). When the other types of expenditures are considered (i.e. victim's lost wages, medical expenses, employer's lost productivity, it is a reasonable to assume the total costs would greatly exceed $8,278 per year. A similar conclusion can be made using the ten year timeline, although one could begin to make the argument that perhaps the total costs do not reach $15,418 per year.

The amortized costs per year calculation is a conservative model that allowed a rough comparison to be made between the costs of the Phoenix Treatment Program per youth, with the conceptual costs that are typically associated with new crimes. A strong argument can be made that the costs of the Phoenix Treatment Program are less than the costs associated with new crimes--or another way of putting it is that the costs of the Phoenix Treatment Program are more than offset by the savings associated with less recidivism as a result of the program. When potential future benefits are conceptually factored in, it is even more reasonable to conclude that the Phoenix Treatment Program is good use of public dollars.

This simplified net present value analysis demonstrated that the Phoenix Treatment Program provides good economic value to Lane County and that even though the program is at face value very expensive per youth (about $73,000), the overall benefits to people living in Lane County outweigh the initial costs of the program. In other words, the Phoenix Treatment Program is effective and provides the tax payers of Lane County good value for their tax dollars.

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# KEY FINDINGS

**THE PHOENIX TREATMENT PROGRAM IS AN EFFECTIVE AND COST-EFFICIENT COGNITIVE BEHAVIORAL PROGRAM THAT BENEFITS YOUTH AND FAMILIES INVOLVED IN LANE COUTNY'S JUVENILE JUSTICE SYSTEM. THE PROFESSIONALS THAT WORK WITH THE YOUTH AND FAMILIES ARE DEEPLY INVESTED IN HELPING YOUTH BECOME SUCCESSFUL. THE PROGRAM HAS BEEN UNDERUTILIZED MOSTLY BECAUSE OF THE RELATIVELY SMALL NUMBER OF YOUTH WHO HAVE BEEN AVAILABLE AND DEEMED A GOOD FIT FOR THE PROGRAM**

This section describes the key findings from the evaluation of Lane County Youth Services Phoenix Treatment Program. The findings are a synthesis of the evaluation work completed during April 2017 through May 2019.

## KEY FINDING 1

The Phoenix Treatment Program had positive effects on the youth who participate. For example, in 2017, youth who participated in the Phoenix Treatment Program recidivated at a lower rate compared to youth who did not participate in the Phoenix Treatment Program (27% compared to 35%). The state of Oregon recidivism rate for 2017 was 28.8%.

## KEY FINDING 2

Lane County Youth Services Phoenix Treatment Program staff, the Juvenile Counselors, the Center for Family Development Treatment Providers, and the Martin Luther King Jr. Education Center staff are highly dedicated to providing strength-based interventions and are deeply invested in helping youth.

## KEY FINDING 3

Lane County Youth Services Phoenix Treatment Program has been profoundly influenced by national and state juvenile justice trends in the past 30 years.

## KEY FINDING 4

The Phoenix Treatment Program has been under utilized since its beginning in 2005. The utilization rate has gradually decreased for the past five years to about 52% in 2018.

## KEY FINDING 5

The "flow" of youth who are good candidates for the Phoenix Treatment Program is very narrow, which has contributed to underutilization of the program. For example, in 2017, there were only 95 youth who were procedurally eligible for the program. Of those 95, only 33

IN 2017 YOUTH WHO PARTICIPATED IN THE PHOENIX TREATMENT PROGRAM RECIDIVATED LESS COMPARED TO YOUTH WHO DID NOT PARTICIPATE IN THE PROGRAM

youth were placed into the Phoenix Treatment Program.

## KEY FINDING 6

The referral process by which youth are placed into the Phoenix Treatment Program aligns with the human services perspective of best practice that includes three components: best available scientific evidence, practitioner expertise and judgment, and what the youth needs to be successful

## KEY FINDING 7

The Phoenix Treatment Program is compliant with state of Oregon Behavioral Rehabilitation Services requirements.

## KEY FINDING 8

The typical youth who participated in the Phoenix Treatment Program 2017 was a white male, 15.6 years old, medium to high risk JCP risk score, classified as an "early starter," with more than five criminal referrals, with a high likelihood of a special education diagnosis, and substance abuse. The typical youth spent 165.5 days (5.5 months) in the program in 2017.

## KEY FINDING 9

The youth and families that participated in the Phoenix Treatment Program during 2018 perceived the program to be helpful, and the staff to be effective and caring adult role models.

## KEY FINDING 10

The point-level system currently being used by the Phoenix Treatment Program does not align with best practices for residential treatment for youth involved in the juvenile justice system.

## KEY FINDING 11

Group Workers in the Phoenix Treatment Program have the most day to day contact with the youth compared to the Juvenile Counselors (JCs) or the Center for Family treatment providers

## KEY FINDING 12

Clear, consistent, adequate, and professional communication between all the parties involved in the Phoenix Treatment Program is challenged by multiple parties separated by location and time.

CLEAR, CONSISTENT, ADEQUATE, AND PROFESSIONAL COMMUNICATION BETWEEN ALL PARTIES INVOLVED IN THE PHOENIX TREATMENT PROGRAM IS CHALLENGED BY MULTIPLE PARTIES SEPARATED BY LOCATION AND TIME

THE PHOENIX TREATMENT PROGRAM COSTS ABOUT $73,000 PER YOUTH, AND THE INITIAL COSTS ARE MORE THAN OFFSET BY FUTURE SAVINGS DUE TO LOWER RECIDIVISM

## KEY FINDING 13

Maintaining a healthy treatment milieu is required for positive outcomes for youth and their families. The treatment milieu has been improved since relocating the program to a residential setting.

## KEY FINDING 14

The delivery of Phoenix Treatment Program services has varying degrees of fidelity to the treatment models, and some methods are not firmly supported in the academic literature.

## KEY FINDING 15

In 2017 The Phoenix Treatment Program had a small disproportionate minority contact (DMC) number for African American and American Indian, Native Hawaiian and Pacific Islander Youth

## KEY FINDING 16

The Phoenix Treatment Program does not provide gender-specific services

## KEY FINDING 17

The Phoenix Treatment Program total costs in fiscal year 2018-19 were $2,495,968. The program is funded by a combination of General Fund tax dollars, Local Option Tax Levy Fund, and Medicaid (Title XIX) dollars.

## KEY FINDING 18

The Phoenix Treatment Program costs about $73,000 per youth and the initial costs of the program are more than offset by future savings due to lower recidivism

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# RECOMMENDATIONS

**THESE RECOMMENDATIONS ARE BASED ON THE EVALUATOR'S CONCLUSIONS AFTER MORE THAN A YEAR'S WORK WITH THE PHOENIX TREATMENT PROGRAM THAT INCLUDED OBSERVING THE DAY-TO-DAY ACTIVITIES, INTERVIEWING YOUTH AND FAMILIES, GROUP WORKERS, SUPERVISORS, THERAPISTS, JUVENILE COURT COUNSELORS, MLK SCHOOL PERSONNEL, AND JUDGES, AND REVIEWING EXISTING PROGRAM DOCUMENTS. THE RECOMMENDATIONS ARE ALSO BASED IN PART ON A REVIEW OF THE ACADEMIC LITERATURE REGARDING BEST PRACTICES IN RESIDENTIAL TREATMENT FOR YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM**

## RECOMMENDATION 1

A periodic review of the Phoenix Treatment Program interventions and treatments should be completed to confirm that they align with best practices for trauma-informed services for youth involved in the juvenile justice system. The review should bring together all parts of the treatment team: Center for Family Development Personnel (Therapists, Behavior Support Specialists, Supervisors), Phoenix Treatment Program Personnel (Group Workers, Supervisors), Lane County Mental Health Specialist II, Juvenile Court Counselors, as well as Martin Luther King Jr. Education Center Personnel.

## RECOMMENDATION 2

Group Workers should have increased opportunities to learn about best practices in trauma-informed treatment for youth involved in the juvenile justice system. Since Group Workers have the most day-to-day contact with youth in the Phoenix Treatment Program, their practice should be regularly calibrated with best practices to ensure treatment fidelity.

## RECOMMENDATION 3

Efforts to increase the utilization of the Phoenix Treatment Program should be carefully considered to evaluate the possible negative effect on the treatment milieu. The "negative peer contagion effect" should be kept in mind, and decisions to increase the program utilization should be made carefully to prevent low-risk youth from mixing with high-risk youth.

## RECOMMENDATION 4

The use of positive youth development measurements should be considered as a supplement to the traditional deficit-based outcome of recidivism. For example, strength-based measurements of school engagement, prosocial activities, family functioning, and employment could be considered.

PHOENIX TREATMENT PROGRAM INTERVENTIONS AND TREATMENTS SHOULD BE REVIEWED TO CONFIRM THEIR ALIGNMENT WITH BEST PRACTICES FOR TRAUMA-INFORMED PRACTICES FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

## RECOMMENDATION 5

Efforts should be taken to better meet the needs of girls in the program via gender-specific treatments and curricula. Also, it should be recognized that some youth participating in the Phoenix Treatment Program will identify at various points along the gender continuum, and their needs should be met in a supportive and responsive manner.

## RECOMMENDATION 6

More efforts should be made to involve qualified community members and groups to become involved providing extra-curricular activities for youth in the Phoenix Treatment Program. For example, there could be an "artist in residence" type of a program where a local artist would provide a series of hands-on workshops for the youth.

## RECOMMENDATION 7

Efforts should be made to find ways to increase youths' autonomy in the Phoenix Treatment Program and to allow a more inclusive decision-making process. Increased autonomy should be integrated with a youth's individual treatment goals and should always

## RECOMMENDATION 8

The current Point-Level system with the associated token economy should be phased out and replaced with a more positive youth development model that helps youth build skills needed for living successfully in the community. The model should address these items: Group Worker's concerns about behavior management, individualized youth's progress through their treatment plan, and positive youth development. The model should be based on best practices in residential treatment for juvenile justice involved youth.

## RECOMMENDATION 9

A review of the communication processes should be completed that includes all parties. The purpose of the review would be to identify ways to increase communication throughout the Phoenix Treatment Program process with youth, families, Juvenile Court Counselors, Group Workers, Therapists, SUDS Counselors, MLK personnel, Culinary personnel, Horticulture personnel, and the Court. Caution is needed in order to prevent creating an unworkable and complicated communication protocols--the idea would be to streamline and improve communication.

THE CURRENT POINT-LEVEL SYSTEM AND TOKEN ECONOMY SYSTEM SHOULD BE PHASED OUT AND REPLACED WITH A MORE POSITIVE YOUTH DEVELOPMENT MODEL

EFFORTS SHOULD BE TAKEN TO BETTER MEET THE NEEDS OF GIRLS IN THE PROGRAM VIA GENDER-SPECIFIC TREATMENTS AND CURRICULA

## RECOMMENDATION 10

Youth and families should be surveyed periodically to gather feedback on how well they believe the Phoenix Treatment Program is serving them. Their feedback will be important to consider as changes to the program are contemplated.

## RECOMMENDATION 11

An investigation of the possible benefits of co-locating the Center for Family Development Therapists and Treatment Coordinator (and perhaps the SUDS Counselors) in the current Phoenix Treatment Program building should be completed.

## RECOMMENDATION 12

A review of the Phoenix Treatment Program "completion" requirements should be undertaken in order to clearly define satisfactory program completion. The definition of satisfactory program completion should be communicated to the Juvenile Court so that compliance with court order can be determined. Satisfactory completion should be individualized based on a youth's treatment goals.

## RECOMMENDATION 13

A review of the communication process with youth and families considering a placement in the Phoenix Treatment Program should be completed. The purpose of the review would be to find ways to improve the understanding of the consequences of successful completion of the program, as well as the consequences of unsuccessful completion.

## RECOMMENDATION 14

A review of the Phoenix Treatment Program curricula (specifically Competency Group, and Treatment assignments) should be completed to confirm they align with best practices for residential treatment for youth involved in the juvenile justice system and alternative education practices.

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# LITERATURE REVIEW

## THE LITERATURE REVIEW PROVIDED THE SCIENTIFIC CONNECTIONS BETWEEN THE PHOENIX TREATMENT PROGRAM AND BEST PRACTICES FOR RESIDENTIAL TREATMENT CENTERS SERVIING YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM

### PURPOSE AND DESCRIPTION

The purpose of this literature review is to provide the academic and scientific nexus to the underlying principles and practices of the Lane County Youth Services Phoenix Treatment Program, and to provide supportive evidence for the Phoenix Treatment Program evaluation. The literature review identifies the theoretical and empirical support for the Phoenix Treatment Program components and practices by highlighting the knowledge base that has developed in the past 50 years regarding residential treatment for juvenile justice involved youth.

### TWO CATEGORIES

The literature review is organized into two main categories: best practices in juvenile justice, and best practice in residential treatment. The section on best practices in juvenile justice describes the overarching features of the developmental processes that influence youths' entry and involvement in the juvenile justice system. The section on best practices in residential treatment describes the significant characteristics of effective residential treatment for juvenile justice involved youth.

The literature review is not intended to be exhaustive but it does represent the general flavor and tone of what is known about best practices in the juvenile justice system generally, and more specifically what is known about best practices in residential treatment for youth. The review highlights the fact that there are significant gaps in the literature and much more research is needed to confirm how best to move forward with improving the interventions for juvenile justice involved youth. Even though the knowledge base is incomplete, it is important to consistently keep in mind the foundational premise of the juvenile court system: youth have unique needs that are related to their physical, emotional, cognitive, social and cultural experiences. In this light, changes to the juvenile justice system should always consider that youth are different than adults and interventions and treatments

should be designed to encourage prosocial development in order to increase the safety of communities. These deep-rooted values should be projected through a strength-based lens in order to develop individualized treatments and interventions to help ensure positive outcomes for youth involved in the juvenile justice system.

## BEST PRACTICES IN JUVENILE JUSTICE

A large number of youth become involved in the juvenile justice system every year in the U.S. For example, in 2017, more than 800,000 youth ages 12 to 18 years of age were arrested (Office of Juvenile Justice and Delinquency Prevention, 2018). The large majority of crimes were nonviolent, mostly property crimes, drug and alcohol offenses, and other "status" crimes (actions that if committed by an adult would not be a crime—i.e. curfew, minor in-possession). About 20% of arrests were for violent person-to-person crimes (Office of Juvenile Justice and Delinquency Prevention, 2018). Most of these youth are boys (about 72%). More than half of the youth (about 56%) are youth of color (Office of Juvenile Justice and Delinquency Prevention, 2018).

*Sharp decreases in Juvenile Arrests:* While there is a large number of youth involved in the juvenile justice system, it is important to note there has been a steep decline in juvenile arrests during the past decade. The 2017 juvenile arrest rate is nearly 60% less than the 2008 juvenile arrest rate (Campaign for Youth Justice, 2018; Office of Juvenile Justice and Delinquency Prevention, 2018). The reasons for this steep decline have remained elusive for researchers and policy makers (Smith, 2019). Despite this decline, the U.S. has the highest rate of youth confinement of any developed country (Justice Policy Institute, 2011).

*Foundationi of Juvenile Court:* There is little clarity around the reasons for the large decrease in juvenile offending, even though the fundamental approach to juvenile justice has remained steady since the juvenile court's inception in the early 1900s (Feld, 2017). The underlying principles of the juvenile justice system were established in the context that youth are fundamentally different than adults and that interventions should adhere to three principles: community safety, accountability, and rehabilitation (Weber, Umpierre, & Bilchik, 2018; National Research Council, 2013).

*"Tough" versus "Smart" on Crime:* There are inherent tensions within these principles, and policy makers, elected officials, juvenile justice professionals, and the general public have wrestled with how best to balance the needs of the community with the needs of the young person who has committed a crime (Hinton, Sims, Adams, & West, 2007). As a result of these tensions, juvenile justice policies and practices have shifted repeatedly between retribution-punishment (community safety and accountability) and rehabilitation (Maloney, Romig, & Armstrong, 1988; Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Perelman & Clements, 2009). These policy shifts have been described as a continuum with the endpoints "Tough on Crime" and "Smart on Crime" (Brooks & Roush, 2014), with "Tough on Crime" associated with retribution and punishment, and "Smart on Crime" associated with rehabilitation.

*Risk/Need/Responsivity Principle:* The pendulum of juvenile justice policy has moved toward "Smart on Crime" in the past 30 years, and the Risk/Need/Responsivity approach (Cullen, 2013; Newsome & Cullen, 2017) has been widely accepted as an organizing perspective that describes best practices for addressing the unique needs of youth involved in the juvenile justice system (Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Maloney, Romig, & Armstrong, 1988; Rocque, Welsh,

Greenwood, & King, 2014). The risk principle assumes that criminogenic risk factors can be identified, and that interventions should be targeted to the highest risk youth (Lowenkamp & Latessa, 2005). The needs principle refers to tailoring interventions to addressing dynamic criminogenic risks (family functioning, peer relationships, school engagement, mental health, attitudes and beliefs about criminal behavior). Responsivity has two tracts. One is a general view that cognitive-behavioral treatments should be emphasized. The other is specific to the youth and the goal of individualizing the treatment based on the "youth's age, developmental stage, race, gender, learning ability, and level of motivation for change" (Rocque, Welsh, Greenwood, & King, 2014). Recently, a fourth principle of effective intervention has been added: Fidelity to the program model should be "maintained throughout the delivery of services" (Pealer & Latessa, 2004, p. 26).

*First, Do No Harm:* As our nation considers how best to move forward with changes to the juvenile justice system, it is important to consider that current research has clearly demonstrated that programs relying heavily on deterrence, incapacitation and control, do not decrease recidivism (Mackenzie, 2012). As changes to the juvenile justice system are considered, a simple underlying value should be kept in mind to ensure positive outcomes for the more than 800,000 youth involved in the system every year: First, do no harm (MacKenzie, 2012).

*Adolescent Brain Development:* Recently, juvenile justice policy has been informed by increased knowledge about adolescent development, including cognitive development associated with brain maturation (Annie E. Casey Foundation, 2011; Steinberg, Cauffman, & Monahan, 2015; Lipsey, Howell, Kelly, Chapman, & Carver, 2010) and there is increasing awareness that adolescents are not merely little adults and have unique needs that are specific to their developmental age (American Academy of Child and Adolescent Psychiatry, 2019; Cauffman & Steinberg, 2012; Coalition for Juvenile Justice, 2016; Newsome & Cullen, 2017; Steinberg, 2013). For example, it is now widely accepted that adolescent brain development affects a youth's ability to judge risks and possible future outcomes (Jones Hubbard, & Matthews, 2008; National Research Council, 2013) In other words, youth involved in the juvenile justice system need different things than adults in order to succeed and that interventions should consider the unique age-related developmental processes that are related to juvenile offending. Feld (2017) and others suggested a youth's involvement in the juvenile justice system is the result of a developmental process—often over years—and that success depends on addressing individual developmental risks and protective factors associated with individual characteristics, family functioning, exposure to trauma, neighborhood environment, peers, socioeconomic status, and larger socio-political factors such as racism, discrimination, and access to services and supports.

There is a growing body of evidence supporting the relationships between adolescent brain development with impulsivity, risky behaviors, and lack of decision-making skills (i.e. Coalition for Juvenile Justice, 2006; American Academy of Child and Adolescent Psychiatry, 2016). Neuroimaging technology has added empirical data that indicates an adolescent's brain continues developing beyond age 18 and into their early to mid-20s (Coalition for Juvenile Justice, 2006; National Research Council, 2013) and that teenagers are more susceptible to recklessness, sensation-seeking behaviors, and risk-taking compared to adults.

Steinberg (2009) categorized the literature that describes the relationships between adolescent brain development

and juvenile crime into four components: peer influence, future orientation, reward sensitivity, and self-regulation. In her review, she found that adolescents are more influenced by their peers compared with adults. Peers have both a direct and indirect influence on adolescent behavior, such as when adolescents might make a risky decision after being convinced by peers in the moment (direct), or when adolescents make a risky decision based on their desire to please peers, or to avoid the disapproval of their peers, without direct coercion (indirect). Dishion's work on the effect of negative peers, and the "peer contagion" effect support the notion that peers have a powerful influence on adolescent decision-making and that negative peers are associated with higher rates of delinquency (Dishion, McCord, & Poulin, 1999; Dishion & Tipsord, 2011). Teenagers' ability to consider the long-term consequences of their decisions is different than adults. Part of this reason is likely due to the fact that teenagers have lived for a shorter amount of time than adults, and therefore have a smaller time-frame in which to compare to—that is, an immediate outcome might have more influence on their decision-making process than a 10-year outcome, because 10 years represents a large proportion of their life. There is also evidence linking the differences between teenagers' and adults' abilities to consider long-term consequences with differences in their brain development, especially in the prefrontal cortex areas responsible for executive functioning (Cauffman, Steinberg, & Piquero, 2005). The literature contains evidence suggesting that adolescents and adults are different in how they experience rewards. For example, adolescents are more susceptible to immediate rewards, which could explain more sensation-seeking behaviors and risk-taking by adolescents compared to adults (Galven, Hare, Voss, Glover, & Casey, 2007). Galvan, et al. (2007) also discussed that adolescents are more impulsive and have less self-management than adults, and that the differences are likely expressed via differences in brain development between adolescents and adults.

*U.S. Supreme Court Decisions:* It is interesting that the science is now confirming the early foundations of the juvenile justice system that recognized youth are different than adults. The recent empirical brain evidence supporting a process of development neurological maturation that takes place between childhood and adulthood is consistent with the original premise of the American juvenile justice system—that youth are fundamentally different than adults (National Research Council, 2013) and should be treated as such. During the past 20 years, the U.S. Supreme Court has weighed in on this issue with a series of decisions that were based in part from the growing body of adolescent brain research. For example, The U.S. Supreme Court recognized the differences in youth brain development and culpability in recent decisions that reversed extreme sentences for court-involved individuals who committed violent crimes as juveniles. For example, before 2005, youth aged 16 and 17 who were convicted of homicide were eligible for the death penalty (Steinberg, 2013). In the 2005 Roper v. Simmons, the Court prohibited states from executing youth for crimes committed before the age of 18, citing age as a mitigating factor and recognizing the reduced culpability associated with age (Feld, 2017). Then, in a series of subsequent decisions, the Court banned or limited the use of life without parole for youth who committed violent crimes as juveniles (e.g. *Graham v. Florida, Miller v. Alabama*). Thus, the highest court in the U.S. has clearly recognized adolescent brain development as a critical factor that must be considered in the juvenile justice system.

## AGE OF FIRST ARREST

The age of onset of criminal behavior and age of first arrest is strongly related to adolescent brain development and is a powerful predictor of future criminal behavior (Eddy, Reid, & Curry, 2002; Loeber & Farrington, 2001; Patterson, Capaldi, & Bank, 1991; Patterson, Crosby, & Vuchinich, 1992). Research has shown that youth arrested before age 14 are more likely to continue their criminal behaviors into adulthood and remain involved in the criminal justice system (Patterson & Yoerger, 2002). There are threads of evidence in the literature suggesting a younger age of first arrest (11 years old to 13 years old) is a more powerful predictor of future criminal behavior (e.g. LeBlanc & Frechette, 1989). While there might be disagreement about the proper age of first arrest to consider, there is strong agreement that adolescent brain development is affected by negative early childhood experiences such as in-vitro drug effects on unborn children, child abuse and neglect, violence, and exposure to chronic and persistent stressors associated with living in poverty (Feld, 2017; Berstein, 2014; National Research Council, 2013; Loeber & Farrington, 1998; Loeber & Farrington, 2001, Alltucker, Bullis, Close & Yovanoff, 2006). Thus, negative early childhood experiences affect a youth's developmental trajectory into the juvenile justice system and beyond.

There are several categorizations referring to the developmental trajectories that lead to age of first arrest and the likelihood of chronic and persistent criminal behaviors. In a widely cited article, Moffitt (1997) described two distinct etiologies of adolescent criminality: life-course persistent offenders, and adolescence- limited offenders. The development of life-course persistent offenders is characterized by family disruption and unhealthy family functioning, leading to early problematic behavior. The early problematic behaviors by the child can make it difficult to learn prosocial behaviors, which can lead to increased antisocial behavior, rejection by peers and adults, school failure, and subsequent criminal behaviors. Moffitt described the resulting cascading negative outcomes as "cumulative continuity," resulting from "early individual differences set in motion a downhill snowball of cumulative problems that increase the probability of offending" (Moffitt, 1997, p.22). Conversely, adolescent-limited offenders have a much less disruptive childhood, and they tend to start their criminal behavior later in adolescence than life-course persistent offenders. Adolescent-limited offenders have fewer years of negative development and therefore less "cumulative continuity" than life-course persistent offenders, and can take advantage of prosocial opportunities, which can lead to desisting from criminal behaviors. In other words, adolescent-limited offenders are more likely to age out of their criminal behaviors than life-course persistent offenders.

*"Early" versus "Late" Starters:* There are many ways to characterize juvenile offenders' developmental trajectories, the relationship with age of first arrest, and the likelihood of chronic and persistent criminal behavior. One typology maps closely with Moffitt's life-course persistent and adolescent-limited theory of juvenile offending, and it focuses on age of first arrest as a significant developmental milestone and strong predictor of future offending. Youth arrested prior to age 14 are generally referred to as "early starters," and youth arrested after age 14 are generally referred as "late starters" (Alltucker, Bullis, Close & Yovanoff, 2006; Patterson, Capaldi, & Bank, 1991), with early starters correlating closely with Moffitt's life-course persistent group, and late starters correlating with Moffitt's adolescent-limited group . Whatever labels are used, these developmentally based typologies are

important for juvenile justice practitioners because each group has distinct risks and needs, and therefore distinctly different treatment and intervention requirements. The developmental trajectory that propels early starters/life-course persistent offenders into the juvenile justice system is characterized by neuropsychological deficits, early childhood trauma, antisocial behavior, association with negative peers, low family functioning, early drug and alcohol use, risky sexual behaviors, and school failure. Therefore, early start youth typically begin their criminal behaviors earlier and arrive at the juvenile justice system with a long developmental history that increases their risk of continued criminal behavior. In contrast, late start youth have a more positive and what is considered a more normal and healthy development, and are at much lower risk of continued criminal behavior.

*Early Negative Childhood Experiences:* Evidence supports the notion that the environment in which a youth grows up in and experiences affects brain development. Researchers have identified that exposure to elevated stress levels in early childhood can have negative effects on adolescent development. For example, recent adolescent brain research indicates that early childhood trauma is associated with persistently higher levels of the brain hormone cortisol, a naturally occurring hormone activated by stress such as child abuse and neglect. While adolescence is a time of normally elevated cortisol levels, chronic and persistently high levels of cortisol have been associated with changes in gene expression (Walker & Bollini, 2002), thus establishing the likelihood that environmental factors (such as trauma) that lead to higher levels of stress can have long term negative effects.

*Family Functioning:* Disruptive family functioning in early childhood and adolescence has been shown to negatively affect adolescent development and is related to early start juvenile offending. Family functioning can be described in negative terms (i.e. "dysfunctional") or with theoretical scalable dimensions ranging from positive to negative. Loeber and Farrington (2001) described family functioning in negative terms, using family dysfunction to include "family disruption, succession of multiple caretakers, parental antisocial behavior, parental substance use, mother's depression, and child abuse and neglect" (p. 14).

Other social scientists construe family functioning in scalable terms. For example, Epstein, Baldwin, and Bishop (1983) described the McMaster Family Assessment Device that contains seven subscales that measure Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning. More recently, Santesteban, et al. (2018) described the Family Adaptability and Cohesion Evaluation Scales-IV (FACES-IV) that measures cohesion and flexibility. Cohesion is related to the degree of autonomy within the family unit, and the emotional bonding between family members. High levels of cohesion are related to enmeshment, low autonomy and high bonding, whereas low levels of cohesion are related to disengagement, high autonomy and low bonding. Extremely high and extremely low levels of cohesion are generally associated with unhealthy family processes and low levels of family functioning. Flexibility describes family leadership, family organization, quality and role of relationships, family control, and rules amongst family members. The FACES-IV Flexibility scale ranges from rigid to chaotic, with healthy levels falling somewhere in-between. Family communication skills facilitate changes in cohesion and flexibility measurements, and include listening and speaking skills, problem-solving, clarity, self-disclosure, and respect. While there is not a clear consensus about specific dimensions of family functioning,

it is clear that family functioning is a complex construct containing elements of communication, adaptability, relationship qualities, roles and responsibilities, appropriate autonomy, and respect. High family functioning is characterized by healthy levels of these components, and low family functioning is characterized by unhealthy levels.

Adolescent outcomes are related to family functioning. For example, the age of first arrest is correlated with low family functioning, family criminality, and educational challenges. In their 2006 retrospective study of 531 previously incarcerated youth in Oregon, Alltucker, et al. found that compared with Late Starters, Early Starters were four times more likely to have experienced foster care (an indication of low family functioning, child abuse and neglect), and nearly twice as likely to have a close family member convicted of a felony. In the same study, 64% of early starters had a Special Education diagnosis, 24% had a Learning Disability (LD), and 41% had an Emotional Disability (ED), although none of these factors were significantly correlated with age of arrest. These figures compare with national statistics that indicate 30% to 50% of youth involved in the juvenile justice system have a special education disability, compared to about 13% of the general juvenile population with a special education disability (National Council on Disability, 2003).

There is a thread of events that weaves throughout an adolescent's development that is correlated with juvenile offending. Low family functioning is related to early negative childhood experiences, and exposure to trauma is also associated with the onset of antisocial behavior and later crime and delinquency (Moffitt, 1997; Patterson et al., 1991). Moffitt's work suggested that earlier onset of antisocial behavior is related to lower self-control and higher impulsivity, which in turn are related to a higher likelihood of chronic criminal behavior. Patterson's work suggested that earlier onset of antisocial behavior is associated with low family functioning, in particular with what he called "coercive family processes." That is, negative early childhood experiences are related to the development of antisocial behavior, and in combination with coercive family functioning, contribute to increased criminality in youth.

*Risk Domains:* The age of first arrest can be contextualized within socio-environmental systems that affect adolescent outcomes. These systems can also be used to conceive risk domains. Loeber and Farrington (2001) identified risk factors for Early Starters that are anchored to five environmental systems: Individual, Family, School, Peer, and Community (Bronfenbrenner, 1979). These risk domains are similar to the risk domains used in Oregon's Juvenile Crime Prevention (JCP) risk assessment that is used to guide juvenile justice interventions and treatment for youth involved in the juvenile court (Oregon Juvenile Department Directors Association, 2019).

*Summary:* In summary, there is strong evidence of the relationship between early childhood negative experiences and the onset of criminal behavior. Early Starters arrive at the juvenile justice system with a set of risks and needs that are deeply associated with trauma and disrupted developmental processes, and therefore have unique treatment requirements that should be considered by juvenile justice practitioners and treatment providers. Evidence suggests that these Early Starters over represent the rather small population of chronic and violent juvenile offenders who are responsible for a majority of juvenile crime, and who are more likely to continue their criminality into adulthood (Loeber & Farrington, 1998). Therefore, it is important to identify Early Starters quickly upon their initial entry into the juvenile justice system so

that appropriate resources can be directed towards them.

In comparison, Late Starters arrive at the juvenile justice system with a developmental history that is typically associated with less early childhood trauma and higher family functioning compared to Early Starters (Alltucker, Bullis, Close & Yovanoff, 2006). Therefore, Late Starters generally have lower risk than Early Starters when compared across the five risk domains (Loeber& Farrington, 2001) and have different treatment requirements than Early Starters, even though both groups are involved in the juvenile justice system. Late Starters are more likely to "age out" of criminal behavior and therefore make up a substantial proportion of what criminologists call the Age-Crime Curve, which shows juvenile criminal activity peaking at about age 17, then decreasing after that (Steinberg, 2009). In other words, Late Starters are more likely to desist their criminal behaviors naturally as they age.

## GENDER DIFFERENCE IN DEVELOPMENTAL TRAJECTORIES

There are distinct differences between the developmental trajectories for girls involved in the juvenile justice system compared to boys (Zahn, Day, Mihalic, & Tichavsky, 2009; Matthews & Hubbard, 2008; McCabe, Lansing, Garland & Hough, 2002; OJJDP, 2010), and there is evidence that girls are more sensitive to many of the negative experiences that lead to juvenile justice involvement compared to boys (OJJDP, 2010). This is important because many girls arrive at the juvenile justice system with more complex developmental histories that are characterized by higher rates of victimization, more childhood trauma, lower family functioning, and higher rates of mental illness, compared to boys (Chesney-Lind & Sheldon, 2004; McCabe, Lansing, Garland & Hough, 2002). While girls remain a minority in the juvenile justice system nationwide, the percent of girls arrested has grown recently in comparison to boys. For example, OJJDP reported that during the decade 2005 – 2015, the percentage of arrests involving boys decreased , while the proportion of arrests involving girls increased to about 30% of all arrests (OJJDP, 2019). The increasing trend highlights the need to effectively address the needs of girls involved in the juvenile justice system so that positive outcomes can be achieved for this vulnerable population.

*Exposure to Trauma and Outcomes:* Girls are typically exposed to more trauma than boys, and have higher levels of victimization (Ford, Grasso, Hawke, & Chapman, 2013), particularly family violence and sexual assault. Dierkhising et al. (2013) found that in a sample of 658 juvenile justice involved youth, girls were twice as likely to report sexual abuse (31.8% versus 15.5%) and four times more likely to have been sexually assaulted (38.7% versuse 8.8%) compared to boys. Girls in the juvenile justice system are two times more likely to experience *complex* trauma compared to boys (Saar, Eptstein, Rosenthal, & Vafa, 2015). Girls in the juvenile justice system have higher rates of mental health diagnoses, such as depression, compared to boys (Stewart & Trupin, 2003). In a review of the literature, Loeber and Keenan (1994) found higher rates of Attention Deficit Hyperactivity Disorder (ADHD), anxiety disorders, and substance use disorders among girls compared to boys with conduct disorder diagnoses.

*Victimization*: Violence and victimization rates are disproportionately higher for girls. For example, Chamberlain and Reid (1994) found higher rates of sexual and physical abuse among incarcerated girls compared to boys. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) reported national statistics of 35%

girls in the juvenile justice system have histories of sexual abuse and 40% reported exposure to domestic violence (OJJDP, 2014).More recently, Dierkhising and colleagues examined data from the National Child Traumatic Stress Network and found that girls were twice as likely as boys to report sexual abuse (31.% versus 15.5 %) and that girls were four times more likely to have experienced sexual assault (38.7 % versus 8.8%). Henggeler Edwards, and Borduin (1987) found higher rates of mother-child conflict in families of female delinquents compared to families with male delinquents, although it should be noted that there are substantial methodological limitations highlighted in the literature (McCabe, Lansing, Garland & Hough, 2002).

There is evidence that the effects of violence and victimization are greater for girls compared to boys (OJJDP, 2010). For example, some studies have suggested that girls might be more sensitive to negative family dynamics and trauma in the home (Dornfield & Kruttschnitt, 1992: Widom, 1991), and that living in dangerous and low functioning families disproportionately increases girls' risk of juvenile justice involvement (Kerig & Ford, 2014). Therefore, girls' reaction to trauma might be more severe, persistent and impactful compared to their male counterparts.

## GENDER SPECIFIC TREATMENTS

Given the unique developmental trajectories for girls that include higher rates of violence and victimization, it is important that gender specific treatment programs are designed to meet girls' specific mental health needs (Cauffman, 2008). While girls accounted for 15% of youth placed in residential treatment in 2015 (OJJDP, 2018), there is a growing recognition for gender-specific treatment and interventions for girls (Hipwell & Loeber 2006).

Girls have higher rates of mental health disorders such as depression, anxiety and posttraumatic stress disorder (PTSD) than boys (Obeidallah & Earls,1999; OJJDP, 2010). Although there are inconsistencies with how PTSD is assessed and categorized, there is general consensus that girls involved in the juvenile justice system are more likely than boys to meet the criteria for PTSD diagnosis (Kerig & Ford, 2014). It is generally agreed that exposure to trauma, especially repeated trauma during childhood and early adolescence has a negative effect on brain development, and can harm emotional , cognitive and interpersonal processes that are important protective factors for avoiding involvement with the juvenile justice system (Kerig & Becker, 2010). Girls exposed to chronic and repeated trauma can experience decreased self-regulation, less interpersonal trust, and diminished problem solving skills, which makes them vulnerable to unhealthy strategies for resolving conflict—such as physical aggression. Trauma exposed girls are also more likely than boys to resort to self-medication strategies (drugs and alcohol) to address emotional regulation issues (Kerig & Ford, 2014; Lipschitz et al., 2003). Given the evidence, it is no surprise that the combination of trauma and addictions propels many girls to increased criminal behaviors and involvement in the juvenile justice system.

*Patriarchal System:* There are additional challenges identified in the literature regarding what treatment and intervention strategies work for girls. One of the most pervasive challenges stems from the historical male-only perspective woven into the original juvenile court system beginning in the early 1900s. Feld (2017) describes the original juvenile court addressed youth crimes, which at the time included boys only. Girls were either not considered by the juvenile court originators, or the rates of

juvenile female crime were so low that they were not a part of the court's agenda. That changed quickly when status offenses were added to the court's purview—these were "noncriminal misbehaviors such as incorrigibility, runaway, truancy, immorality and indecent conduct" (p. 157). Adding status offenses to the juvenile court's jurisdiction resulted in a large increase in the number of girls involved in the juvenile justice system. This structural characteristic remains in place today and is identified as a possible factor in the recent increases in female delinquency. Feld (2017) noted "the perceived increase in the delinquency of girls may actually reflect a relabeling of status offenses" (p. 168)—that is, because there are fewer gender-specific treatment and interventions available for girls, the juvenile court might be influenced to process girls as delinquents.

*What happens when girls are place in programs designed for boys?:* Most juvenile justice practitioners agree there is a need for more gender-specific programs for girls, and that because of the lack of available services, girls are often placed into programs designed for boys (Chesney-Lind, Morash, & Stevens, 2008). However, there is little known about how much male-oriented research can be generalized to female populations (Hoyt & Scherer, 1998; McCabe, Lansing, Garland & Hough, 2002; OJJDP, 2010), or possible iatrogenic effects on girls who participate in male-oriented treatment. There is some evidence that male-oriented programs might be damaging to girls—that is, if girls are placed in male-oriented programs, and in co-ed facilities, there can be unintended negative effects (NCCD Center for Girls and Young Women, 2019). The lack of national progress to develop gender-specific programs for girls in the juvenile justice system is surprising, given that the Office of Juvenile Justice and Delinquency Prevention (OJJDP) recommended in 1998 that girls' programming should be all female, and that girls' unique developmental trajectories, including the effects of trauma, should be incorporated into treatment and interventions. Matthews and Hubbard (2008) outlined five essential elements for working effectively with girls in the juvenile justice system: "(1) using a comprehensive and individualized assessment process, (2) building a helping alliance, (3) using a gender responsive cognitive-behavioral approach, (4) promoting healthy connections, and (5) recognizing within girl differences" (p.495). It should be noted that there is a prevailing lack of rigorous evaluation of gender-specific programs, and that most researchers agree that more study is needed to determine how best to meet the needs of girls involved in the juvenile justice system.

## DIFFERENTIAL MINORITY CONTACT

Youth of color, and especially youth of color living in poverty, are overrepresented in the juvenile justice system nationwide (Coalition for Juvenile Justice, 2014; National Research Council, 2013; Piquero, 2008). Most reviews of the literature reveal that minority youth, especially African American youth are disproportionately represented in nearly every stage of the juvenile justice system (Piquero, 2008). The federal government recognized this issue in 1988 and Congress has attempted to address the disparities with a series of amendments to the Juvenile Justice and Delinquency Prevention Act of 1974, with the most recent change in 2002 (The Sentencing Project, 2014). This latest change defined the problem as "disproportionate minority contact" (DMC), recognizing that disparities exist at all points of contact with the juvenile justice system, including initial arrest, detention, formal processing, waiver to adult court, disposition, and probation (Coalition for Juvenile Justice, 2014; National Council on Crime and Delinquency, 2007; OJJDP, 2012; Piquero, 2008; The Sentencing Project, 2014).

The extent of DMC is significant and persistent, even though there have been substantial efforts to address the issue. For example, despite large decreases in overall national youth arrest rates in the past decade, black youth are still twice as likely to be arrested as white youth. In 2011, black youth were 44 times more likely to be arrested for drug offenses than their white counterparts, despite evidence suggesting that people of all races use drugs at similar rates. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) report from the 2013 National Survey on Drug Use and Health found no significant differences in the rates of illicit drug use between 2012 and 2103 for any racial or ethnic group (SAMHSA, 2014). The cascading negative effects of this disproportionate contact are staggering. The National Council on Crime and Delinquency describe the accumulated disadvantage for African American youth between 2002 and 2004 with these statistics:

African American youth represent:

- "16% of youth
- 28% of juvenile arrests
- 30% of referrals to court
- 37% of the detained population
- 34% of youth formally processed by the juvenile court
- 30% of adjudicated youth
- 35% of youth judicially waived to criminal (adult) court
- 38% of youth in residential placement
- 58% of youth admitted to state adult prison" (p.3)

The federal emphasis on DMC includes measuring the extent of the differences, but it does not include efforts to examine the reasons or causes of DMC (The Sentencing Project, 2014). This is significant because researchers understand that there are many confounding ecological factors with race that could explain the differences, such as socioeconomic status, family functioning, neighborhood characteristics, access to services, or macro level forces such as discrimination and racism. In one of the few studies that examined ecological factors, Johnson (2018) found that childhood trauma had a disproportionate effect on black youth who had three times the risk of being arrested for a violent felony compared to white youth with similar trauma histories. Johnson's study built on previous evidence that black and Latino/a youth are victimized by institutional racism and discrimination that facilitate racial inequities in schools and the juvenile justice system (Alexander, 2010; Rojas-Gaona , Hong & Peguero, 2016).

The literature is incomplete regarding the effects of race, and it is not known for certain if DMC stems from different rates of offending, or from differential law enforcement and juvenile justice practices, or a combination (Loeber & Farrington, 2001; Piquero, 2008). The National Research Council report on Juvenile Crime, Juvenile Justice noted there has been "scant research attention that has been paid to understanding the factors contributing to racial disparities in the juvenile justice system" (McCord, Widom, & Crowell, 2001, p. 258). What is known is that DMC exists at all contact points of the juvenile justice system (The Sentencing Project, 2014). Therefore, the needs of youth of color involved in the juvenile justice system will not be met satisfactorily until their developmental pathways into the juvenile justice system are more completely understood.

## RISK-NEED-RESPONSIVITY MODEL

The Risk-Need-Responsivity (RNR) model is a widely adapted perspective that informs practice in the adult

criminal justice system (Ward, Mesler & Yates, 2007). The body of literature describing RNR is impressive and supports the developer's claims that RNR, if properly applied, can reduce recidivism (Latessa & Lowenkamp, 2006). Although the underlying principles of RNR have been widely implemented and studied in the adult criminal justice system, RNR has been less widely implemented and studied in the juvenile justice system (Brogan, Haney-Caron, NeMoyer, & DeMatteo, 2015). RNR theory was first introduced in 1990 by Andrews, Bonta and Hoge as a guide for effective offender rehabilitation (Andrews, Bonta, & Wormith, 2011) and since then, has been studied extensively and has been confirmed to be an effective tool to reduce recidivism in adult populations.

The model originally proposed by Gendreau (1996) contained three components: Risk, Need, and Responsivity. Those three principles are described as follows:

- "Risk Principle--match level of program intensity to offender risk level; intensive levels of treatment for higher risk offenders and minimal intervention for low-risk offenders
- Need Principle--target criminogenic needs or those offender needs that are functionally related to criminal behavior
- Responsivity Principle--match the style and mode of the intervention to the offender's learning style and abilities" (Andrews, Bonta & Wormith, 2011, p. 735)

*Risk:* The Risk principle implies the importance of correctly identifying the risk of recidivism, and then classifying the person as low, medium or high risk level (Brogan, Haney-Caron, NeMoyer, & DeMatteo, 2015). This is important for two reasons. One is that research supports the idea of separating low risk youth from high risk youth to avoid the negative peer contagion effect, or "deviancy training" (Dishion, McCord, & Poulin, 1999). Research has demonstrated that placing low risk youth in intensive programs intended for high risk youth is related to decreased outcomes for the low risk youth (Lowenkamp & Latessa, 2004). In other words, low risk youth should receive minimal or no intervention (Ward, Messler, & Yates, 2007). The other reason for identifying risk is to focus finite juvenile justice resources on the youth who need the most intensive interventions, so that treatment program resources are not wasted.

*Needs:* The Needs principle refers to identifying the dynamic criminogenic needs (crime producing needs) of youth to reduce recidivism (Brogan, Haney-Caron, NeMoyer, & DeMatteo, 2015; Latessa & Lowenkamp, 2006; Ward, Mesler & Yates, 2007). Criminogenic needs have been identified as procriminal attitudes, antisocial personality, procriminal associates, history of antisocial behavior, substance abuse, circumstances pertaining to family/marital, school/work, and leisure/recreation (Brogan, Haney-Caron, NeMoyer, & DeMatteo, 2015).

*Responsivity:* The Responsivity principle requires that correctional treatment programs should be tailored to align with the person's individual learning style, characteristics, and motivation (Ward, Messler, & Yates, 2007). The Responsivity principle recognizes that each individual has unique strengths and weaknesses that should be considered to increase the likelihood of treatment effectiveness. Latessa and Lowenkamp (2006) coined the phrase "Treatment Principle" as a more comprehensive term that describes the "how" to effectively address needs. They suggested that behavioral programs that focus on present circumstances and risk factors are more effective than programs that focus on past events

or risks—the idea that focusing on dynamic risk factors (present-day, mutable factors such as associations with negative peers) rather than on static risk factors (past, immutable factors such as child abuse) will result in lower recidivism.

*Fidelity:* In 2004, Pealer and Latessa described fidelity as an additional component to the RNR model, with fidelity defined as "program integrity should be maintained throughout the delivery of services" (p.26). The addition of program fidelity to the RNR model allows for evaluators of juvenile justice programs to describe how well programs adhere to the treatment or intervention model.

*Criticisms of RNR Model:* There are criticisms of the RNR model that have caused the originators of RNR to issue clarifications. For example, in 2003, Ward and Stewart suggested that RNR was a deficit-based strategy that ignored important components of motivation, identity and agency, goods and human nature, the importance of noncriminogenic needs, contextual and ecological factors, and that RNR was a "one size fits all" model. Ward and Stewart proposed that the focus on risk, needs, and responsivity has led to a lack of investigation into the theoretical underpinning of the RNR model, and that additional components should be considered for the model to address its shortcomings. Ward and colleagues have suggested an addendum to RNR called the Good Lives Model (GLM) in a series of publications (Ward, 2010; Ward & Gannon, 2008). In these articles, GLM is characterized as a strength-based model as opposed to RNR which they describe as a deficit-based model.

There are additional criticisms of the RNR model around the issue of risk assessment, and the philosophy that RNR assumes that dynamic risk factors are the same for boys and girls (Vitopoulus, Peterson-Bidali, & Skilling, 2012). A growing body of research suggests that gender neutral risk assessments might not be appropriate for girls, given the fact that most empirical research on adolescent offending has been conducted predominately with boys. There are fears that using risk assessments that have been developed mostly for boys might erroneously categorize girls as high risk, thus subjecting them to sanctions that could make underlying problems worse (mental health, sexual abuse, unhealthy relationships) (Hannah-Moffat & Shaw, 2001). That is, mischaracterizing girls as high risk could mistakenly propel girls deeper into the juvenile justice system, exposing them to truly high risk youth, thus allowing for the possibility of negative peer contagion and additional trauma—the results of which could lead to negative outcomes for girls.

*Expanded RNR Model:* In 2011, Andrews, Bonta and Wormith published a rebuttal to Ward et al, and included a detailed explanation of the RNR model which they claimed addressed some of Ward's concerns, pointing out that the RNR model hadn't changed, but the way that the model was described had been clarified.

## HUMAN SERVICE APPROACH

The original authors of the RNR model, and subsequent collaborators and advocates, have highlighted the importance of implementing a human services component into the RNR delivery. Latessa and Lowenkamp (2006) noted "Most researchers who have studied correctional interventions have concluded that without some form of human intervention or services there is unlikely to be a significant effect on recidivism from punishment alone" (p.521). Andrews, Bonta, and Wormith (2011) in their expanded RNR model, highlighted human services as one of the four overarching principles of the model (respect for the person, theory, and crime prevention being the other three).

*Evidence-Based Practice:* The human service approach is a term used to describe human service practice within an evidence based practice (EBP) framework. EBP arose in the medical profession more than a century ago, as a way to distinguish science from quackery (Spring, Neville, & Russell, 2012), and it has expanded since then to include all health professions, including social workers and behavioral health practitioners. Sackett, Rosenberg, Gray, Haynes, and Richardson (1996) were some of the first to describe the topography of EBP, and their original definition has informed practice to present day.

*Three Components of EPB:* They identified three main components of EBP: Current best evidence, practitioner expertise and professional judgement, and client needs. This triad perspective was an affront to many in academia at the time because it directly challenged the notion that positivism (the view that science should only measure what can be observed) should be the fundamental pillar of scientific inquiry. Positivists believed that empiricism (that observation and measurement is the core of scientific progress) was sacrosanct, so suggestions that EBP should include practitioner judgement and client needs, were heretical. EBP presented another challenge for the positivists in that the evidence should be "the best available" and was not limited to randomized controlled trials (Davis & Gray, 2017).

*Overreliance on Randomized Control Trials:* Since the time that Sackett et al. (1996) proposed the EBP components, there has been a shift towards a post-modernistic approach to medical and social work, and a general acceptance of the EBP model. Policy makers have been slow to follow however, and vestiges of a positivist-heavy perspective of narrowly focused evidence based policy decisions remain. What that means is that many policy makers overemphasize the value of randomized controlled trials, systematic reviews and meta-analysis to guide their policy decisions. Pawson (2006) weighed in on this issue by pointing out that heavily controlled scientific studies could not account "for the complexities and intricacies of human service settings to which the evidence must be transferred" (p.5). To translate that into policy guidelines--policy makers should not oversimplify their policy decisions based on an overreliance on the "gold standard" of randomized controlled trials that might be difficult to translate into individualized settings. Sholonsky and Gibbs (2004) translated this perspective into a three-phased approach that included best evidence available, practitioner's individual expertise, and the client's values and expectations. If a Venn diagram is drawn with three circles containing these three components, evidence-based practice is found in the middle overlapping area of the circles.

*Positivism versus Postmodernism:* All of this is not to say that scientific evidence should be ignored—quite the contrary. Instead, EBP should consider the best available scientific evidence at the time as one of the three sources of information upon which to make a decision. Plath (2008) suggested a recasting of the triad into four parts: positivism, pragmatism, politics, and postmodernism. Positivism recognizes the value of empirical scientific inquiry and the hierarchal relationship where research directs practice. Pragmatism addresses the relevance of scientific evidence given the symbiotic relationship between research and practice. The Political lens considers the usefulness of scientific information for lobbying and advocacy purposes. Postmodernism recognizes the role of the practitioner and her interpretations of the meanings of experiences and how perceptions of evidence are shaped by discourse.

*Correctional Quackery:* The debate concerning positivism

versus postmodernism caught the attention of Gendreau, one of the original architects of the RNR model components. Gendreau addressed concerns about an overemphasis on practitioner expertise, and the problems associated with a common sense approach to offender treatment as opposed to reliance on empirical evidence (Gendreau, Smith, & Theriault, 2009). Gendreau said "what has occurred in correctional treatment under the guise of common sense has been alarming" (p.385) and suggested that many policy makers' thinking about what works in offender treatment existed in a parallel universe to what the empirical literature contains—that is, many policy makers were out of step with what works in correctional programming. Latessa, Cullen, & Gendreau (2002) coined the term "Correctional Quackery" (CQ) to describe this phenomenon. As evidence, Gendreau et al., (2009) pointed to an unpublished meta-analysis that he co-authored that found 87% of the programs examined did not mention the RNR model, nor discuss therapeutic integrity.

*Example: Bootcamps:* There is additional published evidence of CQ in the literature worth noting. Boot Camps came into fashion in the adult correction system in the early 1980s with much fanfare about their effectiveness to reduce recidivism, but without evidence suggesting that they worked. The general model of Boot Camp interventions were short term residential programs that simulated military basic training and that participants needed to be broken, then built back up in order to become noncriminals. Soon after, Boot Camp programs started in the juvenile justice system and proliferated across the country even though there was no empirical evidence that demonstrated their effectiveness. Evaluation evidence that showed either no change in recidivism or an increase in recidivism as a result of Boot Camps began to be published in the late 1990s (Latessa, Cullen, & Gendreau ,2002), which diminished the reputation of Boot Camps. Today, Boot Camps are not considered as EBP programs, and their use has decreased considerably. The implementation and proliferation of Boot Camp programs is in direct opposition to Plath's (2008) suggestion that policy makers tend to overemphasize empirical evidence, and serves as a reminder about the importance of adhering to the principles of what works in juvenile justice.

In summary, EBP in juvenile justice has evolved to include a human services approach which considers scientific evidence, client needs and practitioner experience. Policy makers should pay close attention to the principles of what works in juvenile justice when making decisions about what programs to initiate, promote and sustain.

## STRENGTH BASED APPROACH

The Strength Based Approach (SBA) to social work emerged in the past 50 years as a response to the traditional problem-based, or deficit based approach that identifies and treats pathologies (Nissen, 2006). The perspective that problematic behaviors are a result of deviation from what is considered normal behavior has been deeply embedded into the helping profession psyche, and is codified in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is widely used by health care professionals around the world, and provides descriptions, symptoms, and other criteria for diagnosing mental disorders (American Psychological Association, 2019). SBA takes an alternative view of problematic behaviors and the treatment framework that facilitates improved health outcomes. Polk and Kobrin (1972) were early proponents of applying SBA to youths and they proposed a list of 14 rules that should be considered when working with young people. Since then, the principles of

SBA have been widely accepted in human service fields including social work and mental health, although there is inherent tension between SBA and a mental health field that remains deeply committed to the DSM deficit based perspective. Despite the fact that SBA has gained partial acceptance in these large systems, it has been less accepted in the juvenile justice system, and there is incomplete understanding about the prevalence and effects of SBA in the juvenile justice system.

*Juvenile Justice System Slow to Catch On:* The reasons for the substantial gap in the juvenile justice literature are understandable given the long history of problem-based interventions and a pervasive history of corrections-oriented thinking in the juvenile justice system. Even though the early proponents of the juvenile justice system emphasized rehabilitation as a founding principle, the term has been historically viewed predominantly through a deficit-based lens. That is, the road to rehabilitation has been primarily characterized as reducing risks and addressing needs. For example, the Risk/Need/Responsivity (RNR) model that pervades the juvenile justice system today contains this deficit-based philosophy--so it's no wonder that SBA approaches have been slow to gain acceptance. The way that youth are characterized in the juvenile justice system, and in fact how the majority of research is framed, is from a deficit-based perspective. For instance, youths' problematic behaviors are often conceptualized as deviance from accepted social norms, and are studied by identifying deficits in their personality and behavior—such as impulsivity, immaturity, anxiety, depression, aggression, school failure, risky sexual behavior, and substance use (Nissen, 2006).

Nissen (2006) described SBA as "an organizing principle for a family of theories and practice strategies which have in common a focus on the generally untapped gifts, positive attributes, and under-developed capabilities of persons, families, and even communities, who are in some way compromised in their abilities and/or seeking help for problems" (p.41). Saleeby (1996) was an early promoter of SBA and he stated that a strength-based perspective "demands a different way of looking at individuals, families and communities" (p. 297). In 1997 Saleeby published a seminal work on SBA and suggested this approach to working with people:

- "Every individual, group, family, and community has strengths
- Trauma and abuse, illness, and struggle may be injurious, but they may also be sources of challenge and opportunity
- Assume that you do not know the upper limits of the capacity to grow and change, but take individual, group, and community aspirations seriously
- We best serve clients by collaborating with them
- Every environment is full of resources" (Saleeby, 1997, pp. 12-15)

*Important Questions:* There are indications that SBA is beginning to make its way into the juvenile justice system, facilitated by concerns about iatrogenic effects for justice involved youth, especially youth who are deeply enmeshed in the system. In this light, policy makers, practitioners and the general public have questioned the very rationale of the juvenile justice system and interventions that are punishment based and individual based. The following questions strike at the very heart of many juvenile justice systems (Butts, Bazemore, & Meroe, 2010):

- If it is assumed that delinquent behavior is associated with a lack of integration with family, school and

community, why do juvenile correctional strategies focus on isolating offenders?

- If the goal is increased accountability and responsibility, why do a lot of juvenile justice interventions place youth in treatment programs where adults assume responsibility for their activities and behaviors in the program?
- If some of the root causes of delinquency are found within families, schools and communities, why do many probation strategies focus on only the individual?

*Youth Competency Assessment:* If SBA principles are to be implemented in the juvenile justice system, then a review of the Risk/Need/Responsivity model is needed. Part of the movement toward SBA in the juvenile justice system includes an addition to the traditional risk assessment process. In 2005, Mackin, Weller, Tarte and Nissen reported on the results of their study that examined the implementation of the Youth Competency Assessment (YCA) in three juvenile justice jurisdictions located in the northwestern United States. The authors concluded their project demonstrated the YCA's utility in identifying youth strengths that were subsequently incorporated into case plans. More importantly, the YCA was seen as a supplement to the traditional risk assessments being used, and that the information gained from the YCA could lead to better outcomes for youth and families. An important feature of Mackin's et al. work was a discussion about the impacts of system change on front-line staff, supervision, and administration. SBA represents a change from a command and control environment, and a move away from a deficit based approach to working with youth in the juvenile justice system. It is not a surprise that such a large scale shift in philosophy can present challenges for juvenile justice staff who might feel unappreciated for their previous work, or feel concerned about their personal safety, or feel unsure about their futures in the profession.

*Real Life Example:* About the same time as Mackin's et al. pilot study, the Johnson Youth Center, a juvenile justice center located in Anchorage, Alaska was attempting to move to a SBA approach to assessment and case planning in their secure treatment unit. The Johnson Youth Center Treatment Unit (JYCTU) was part of a larger facility complex that held 22 boys ages 15 – 18 who had been adjudicated for moderate to serious crimes (Barton & Mackin, 2012). According to the authors, the culture at JYCTU had evolved into a command and control environment with an emphasis on punishment and retribution. The staff and youth reported a tense atmosphere that was punctuated with frequent conflict and violence. As is the case in many juvenile facilities, staff often created treatment goals with little input from youth or their families, and there was little variation in the treatment goals between the youth. A new superintendent facilitated the SBA study and pre and post measurements, as well as follow up measurements were performed in areas of incidents, social climate (as perceived by youth and staff), and recidivism. Results after four years indicated lower rates of incidents, improved perceptions of social climate from both youth and staff, and a slight decrease in recidivism rates as compared to other Alaska Department of Juvenile Justice.

*Future Reforms:* Other prominent researchers and policy makers have proposed SBA for the juvenile justice system. Writing for the Coalition for Juvenile Justice, Butts, Bazemore and Meroe published a concept paper in 2010 that originated the term "Positive Youth Justice" (PYJ) as a way to conceptualize SBA in the juvenile justice system. Their paper documented the history of the SBA

movement and its theoretical foundation that is grounded in positive youth development. Readers might be aware of The Search Institute "40 Developmental Assets" framework that has informed the development of positive youth development programs in areas outside of the juvenile justice system, and is a fundamental element of PYJ (The Search Institute, 2019).

In summary, SBA (and its juvenile justice specific PYJ) is not a particular program or set of programs, but rather a fundamentally different perspective that views youth as resources with inherent strengths that are encouraged and developed to produce healthy and positive outcomes for adolescents (Butts, et al., 2010). SBA's have the potential to tap into the inherent strengths of youth, families and communities in new ways that are inclusive of culture, tradition, and community norms (Nissen, 2006). For anyone interested in improving the outcomes for youth involved in the juvenile justice system, SBA provides an intriguing possibility that needs to be further researched.

## BEST PRACTICES IN RESIDENTIAL TREATMENT FOR JUVENILE JUSTICE INVOLVED YOUTH

Residential treatment centers (RTCs) are an intensive intervention that is often used for high risk youth (Orlando, Chan, & Morral, 2003). Juvenile justice involved youth represents a small subset (8%) of the total number of youth placed in RTCs, according to a 2010 survey by Sternberg, et al. The RTCs typically house youth with significant behavioral, psychiatric, psychological and substance abuse problems who have been unsuccessful in less restricted settings but have not yet been sanctioned to secure youth correctional facilities or secure psychiatric facilities (OJJDP, 2011). While the number of juvenile justice involved youth placed in RTCs has decreased 48% in the past decade, a significant number of youth are referred to residential treatment centers (RTCs) every year. For example, in 2015 (the latest data available) 48,000 juvenile justice involved youth were place in RTCs nationwide (OJJDP, 2018).

*Youth Demographics:* Most youth referred to RTCs in 2015 were between the ages of 15 and 17 years of age. Girls accounted for about 15% of the youth placed in RTCs and they tended to be slightly younger than their male counterparts. Minority youth were overrepresented in RTC placements, accounting for 67% of placements. Youth who were committed to RTC as a court ordered disposition spent an average of 113 days in the facilities. Boys tended to stay longer than girls. For example 33% of committed boys remained in RTC placement after 180 days compared to 25% of committed girls; and 12% of committed boys remained in RTC placement after one year compared to 7% of committed girls (OJJDP, 2018).

*Treatment Services:* RTCs typically provide a variety of treatment services for youth, including individual, group, and family mental health counseling, substance abuse treatment, alternative education, behavioral management and medication management, all in a 24-hour supervised setting (OJJDP, 2011). Generally, RTCs are differentiated from group homes that provide less intensive treatment and tend to concentrate on basic needs of food, clothing, shelter and daily assistance. RTCs provide basic needs in addition with concentrated therapeutic treatment services (Bates, English, & Kouidou-Giles, 1997).

*Costs of Residential Treatment:* Residential treatment is extremely expensive (Noftle, Cook, Leschied, St. Pierre, Stewart, & Johnson, 2011). Given that large numbers of juvenile justice involved youth are referred to residential treatment every year, it is important to examine the

outcomes to determine if the large amount of time and money put toward RTCs is effective.

*Treatment Components:* There is little consensus in the academic literature about the effectiveness of residential treatment—mostly because there is not a widely accepted definition of residential treatment (Bettman & Jasperson, 2009; OJJDP, 2011). This is problematic because there is a lack of evidence supporting the large expenditures of public funds to these types of programs. The literature more clearly describes the components of best practices for residential treatment for youth who have significant behavioral, emotional, or substance abuse issues (Bettmann & Jasperson, 2009; Ford & Blaustein, 2013; Ford & Hawke, 2012; Ford, Chapman, Hawke, & Albert, 2007; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; OJJDP, 2011; Orlando, Chan, & Morral, 2003).

This review will consider nine dominant components within the literature that are applicable to the Phoenix Treatment Program: Trauma informed Mental health services, Therapy Foundations, Staff Selection and Training, Optimal Length of Stay, Programs for Girls, Token Economies, Drug Abuse Treatment, Collaborative Problem Solving and Alternative Education.

## TRAUMA INFORMED MENTAL HEALTH SERVICES FOR JUVENILE JUSTICE INVOLVED YOUTH

Given that most deeply involved youth in the juvenile justice system have experienced significant trauma (Ford, Chapman, Hawke, & Albert, 2007) it is important to examine the role of trauma informed interventions. Most youth in residential treatment settings have experienced multiple psychological and physical traumas, and the effects of those traumatic events strongly influence the youths' emotional and behavioral needs and outcomes. Trauma plays a significant role in shaping the psychosocial, emotional, and physical behaviors of youth in the juvenile justice system (Ford & Hawke, 2012; Ford & Blaustein, 2013), and most juvenile justice involved youth have more trauma experiences compared with non-juvenile justice involved youth (Abram, et al., 2013; Baglivio, et al., 2014). Trauma plays a key role in their mental health and behavioral needs, and the effectiveness of rehabilitative programs (Ford, Chapman, Hawke, & Albert, 2007). There are gender differences in the rates of trauma experienced by girls in the juvenile justice system compared to boys in the juvenile justice system. And there is increasing evidence pointing towards the disproportionate role that trauma plays in girls in the juvenile justice system and the different treatment needs required by girls compared to boys (Zahn, Day, Mihalic, & Tichavsky, 2009). Therefore, interventions for juvenile justice involved youth should consider the effects of trauma, and the differential effects on girls and boys.

The prevalence of serious mental health problems, and the relationship to trauma exposure, are prominent themes in the literature (i.e. Brown, McCauley, Navalta, & Saxe, 2013; Ford, Chapman, Hawke, & Albert, 2007). The effects of trauma are well documented. For example, youth who have experienced multiple traumatic events are more likely to have impaired abilities to delay gratification, have extreme emotional reactions (both blunted and excessive), and have "rigid, impulsive, and disorganized thinking and coping styles" (Ford & Blaustein, 2013, p. 667). The rates of Post-Traumatic Stress Disorder (PTSD) is more prevalent among youth in the juvenile justice system compared to youth in the general population (Cruise & Ford, 2011). Clinical expression of trauma disorders include aggression, anger, anxiety, conduct disorder, depression, impaired information processing, impulse

control problems, problems with personal boundaries, sleep disruption, substance use, and suicide ideation and suicide attempts (NCMHJJ, 2016). Studies have reported a wide range of PTSD rates among youth in the juvenile justice system, from 3% to 50% (Abram, Teplin, Charles, Longworth, McClelland, & Duncan, 2004; Cruise & Ford, 2011; Wolpaw & Ford, 2004)

The National Center for Mental Health and Juvenile Justice's (NCMHJJ) comprehensive report in 2016 described important mitigating factors that affect the severity of a youth's reaction to trauma exposure, which should guide treatment interventions. Preexisting risk factors at the time of trauma exposure should be considered. For example, youth who have lower levels of risk prior to experiencing trauma are more likely to have more positive outcomes compared with youth with higher levels of risk prior to experiencing trauma. Another way of saying this is that youth who have more protective factors (individual, family, school, community) at the time of the trauma exposure are more likely to be less affected than youth with fewer protective factors. Another important feature of the trauma experience is whether the youth experienced single or multiple trauma events. Multiple trauma events and chronic trauma are associated with higher rates of PTSD in youth. Youth who have experienced multiple trauma and/or long-term chronic trauma are more likely to "require longer and more intensive treatment in appropriate trauma-informed care environments" (NCMHJJ, 2016, p. 6).

*Intentional and Unintentional Trauma:* NCMHJJ's report also noted differences in trauma-related disorders between intentional trauma victimization (eg. child abuse/neglect) and unintentional trauma victimization (eg. severe accident or illness). Youth who have experienced intentional victimization trauma are more likely to develop trust and relational deficits compared to youth who have experienced unintentional victimization. Both groups require trauma-informed treatment but the approaches, intensity and duration of care will likely be different.

*Iatrogenic Effects of the Juvenile Justice System:* The literature contains evidence of concerns regarding the juvenile justice system's effectiveness in addressing the needs of trauma exposed youth, especially given the concern that the system itself could be contributing additional trauma to already victimized youth (Cécile & Born, 2009; Gatti, Tremblay, & Vitaro, 2009). That is, there is concern that the juvenile justice system could have unintended negative effects on the youth it is supposedly helping.

Some of these concerns come from the highest law enforcement agency in the nation. In 2012, the U.S. Department of Justice (DOJ) recognized that the juvenile justice system has a responsibility for the youth in the system, and there is likelihood that the system itself could be contributing additional trauma. The DOJ issued this recommendation: "Abandon juvenile justice correctional practices that traumatize children and further reduce their opportunities to become productive members of society" (p. 177).

*Residential Treatment Center Staff Exposure to Trauma:* Clearly, trauma exposure is an important feature to consider when designing appropriate residential treatment programs for youth in the juvenile justice system. Exposure to trauma not only affects the youth in juvenile justice settings, but also the staff in those facilities. Research has explored a parallel influence that trauma has on the staff in residential treatment centers, in the form of vicarious trauma and additional negatives effects resulting from constant vigilance during working hours (Pearlman & Caringi, 2009). Staff working in residential treatment

centers is frequently exposed to intense behavioral and emotional needs of highly traumatized youth, including extreme and high risk behaviors, such as self-harm and assaults. Given this, it is important to note the effects of trauma on both the youth receiving treatment and the effects of trauma on the staff. The interactions between these two groups affect youth outcomes, especially if staff behavior relies on a command and control approach. For example, in many residential treatment facilities for juvenile justice involved youth, the primary emphasis is on reducing negative behaviors rather than increasing positive youth behaviors, which can mean that staff emphasize behavioral control and consequences rather than focusing on core causes of negative behavior that stem from the youth's exposure to trauma.

*Organizing Framework for Treatment Services:* In 2013, Ford and Blaustein proposed that self-regulation can be used as an organizing framework from which to design trauma-informed residential treatment for trauma-affected youth. Self regulation is generally thought to contain four abilities: 1. consciously focus attention; 2. Be aware of one's environment, physical and emotional body states; 3. Draw on memory to learn from the past and adapt effectively in the present; 4. Maintain or regain emotional states that lead to well-being and further self-regulation. Structuring juvenile justice residential treatment centers to increase self-regulation is a direct method to help youth recover from complex trauma.

Ford and Blaustein suggested the principles of self-regulation apply to best practices for staff as well. The authors put forth that staff's ability to self-regulate is affected by their exposure to actual trauma, potential traumatic stressors, and vicarious trauma. Exposure to these traumas can reduce self-regulation, which in turn can affect how staff relates to the youth in their care.

They further pointed out that staff are primarily trained in behavior management techniques, but not always trained in areas of interpersonal communication and other methods that increase positive engagement with youth. The result can be a trauma-affected youth population interacting with a trauma-affected staff population, which can lead to negative outcomes for both groups. Treatment outcomes depend on the quality of the relationships between residential treatment staff and youth (Pumariega, 2006).

Moving forward, the National Center for Mental health and Juvenile Justice (2016) recommended the following guide to develop trauma informed services in the juvenile justice system:

- Universal screening to identify potential psychiatric conditions, including traumatic stress disorder, that require further assessment
- Assessment for youth who "screen in" to determine the need for follow-up treatment
- Access to evidence-based or promising interventions to treat and address trauma disorders (p.4)

## EXISTING TRAUMA-INFORMED TREATMENT SERVICES

Three trauma informed treatment programs for youth in RTCs were revealed in this literature review that are applicable to the Lane County Youth Services Phoenix Treatment Program: The Attachment, Regulation and Competency (ARC) model (Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005) , The Sanctuary model (Bloom, 1997), and the Trauma Adaptive Recovery Group Education and Therapy (TARGET) model (Ford & Russo, 2006). The ARC and Sanctuary models were originally developed for youth in residential treatment

programs and have started to be used in juvenile justice settings. The TARGET model was originally designed for the treatment of PTSD and co-occurring substance abuse issues in adults. Recently, TARGET has been tested with juvenile justice involved youth.

*Attachment, Self-Regulation and Competency (ARC):* The ARC framework is not a manualized treatment protocol, but instead proposes a flexible three-pronged approach embedded within a resiliency framework to address the effects of trauma in children. The strength-based model is based on a human services perspective that considers scientific evidence, practitioner expertise and judgement, and the needs of the child (Sackett et al., 1996). The ARC framework has been applied in a variety of settings including residential treatment centers, group homes, therapeutic foster care, and outpatient treatment programs (Ford & Blaustein, 2013). The theoretical foundations of ARC will be presented here. For detailed treatment components, see Kinniburgh et al., 2005.

The primary component in the model is Attachment, and the developers consider it to form the basis for the development of all other competencies, including emotional regulation, behavior and attention—that is, positive attachment is the primary requirement of prosocial behavior. Attachment describes the mother (usually) and child bond which is how infants learn to trust or mistrust their environments and relationships and therefore lays the groundwork for future interactions (Loeber & Farrington, 2001). Shaw and Bell (1993) proposed that healthy (or secure) attachment allows children to trust the people around them to meet their needs, and therefore are motivated to act in prosocial ways to please those around them. In contrast, disrupted (or insecure) attachment is related to children not trusting the people around them to meet their needs, and therefore are less invested in prosocial behavior. Kinniburgh et al. (2005) added that a child who is abused and/or neglected is forced to rely on underdeveloped coping skills such as anger, aggression and disassociation, and that in the absence of healthy family functioning required to develop healthy coping skills, is often forced to rely on the same underdeveloped skill set in dealing with unmet needs. The outcomes of insecure attachment include long term difficulties in multiple realms such as prosocial relationships, chronic anger, and anxiety (Loeber & Farrington, 2001).

Self-Regulation is the next component of the ARC model, and refers to the process in which a child connects with their emotional experiences. Gottfredson and Hirschi (1990) described this as "self-control" and suggested that early negative childhood experiences have a detrimental effect on a child's ability to develop healthy self-control. Ford and Blaustein (2013) described self-regulation as having four parts: attention, awareness of the surrounding environment and awareness of one's physical and emotional states, employing memory to learn from the past and apply to the future, and maintaining emotional states that lead to further self-regulation. Exposure to trauma can negatively affect a youth's ability to formulate self-regulation which in turn, can decrease the youth's ability to successfully cope with stressors. Self-regulation is associated with setting and pursuing goals, and therefore youth with low self-regulation often have difficulties in goal setting and goal attainment. Youth who have experienced multiple trauma or chronic and persistent trauma may suffer from hypervigilance as a result of repeated trauma exposure. This in turn can lead to triggering events that cascade from cues that would normally not be considered threatening or particularly stressful (Kinniburgh et al., 2005).

The "C" part of ARC relates to Developmental Competencies, and the developers identify four components of competency: interpersonal competency, intrapersonal competency, cognitive competency and emotional competency. Exposure to trauma can decrease a youth's development in all four categories, which can lead to decreased functioning.

*The Sanctuary Model:* The Sanctuary Model is a patented and trademarked program first proposed by Bloom in 1997. Since then, it has been tested in a variety of youth oriented residential settings, including residential settings within the juvenile justice system (Rivard et al., 2003). The model relies on creating a therapeutic community that draws upon the strengths of staff and youth to create a "safe, supportive, stable, and socially responsible" healing environment (Rivard et al., 2003, p. 139). A key goal of the Sanctuary model is to change the residential treatment facility's organizational culture into a nonviolent and democratic therapeutic community in which staff and youth are the key decision-makers and participants in creating a healing environment that addresses the damaging effects of interpersonal trauma. Rivard et al., (2003) recognized that trauma not only affects youth, but also the staff and frontline workers who are exposed to job-related stressors associated with working closely with youth with significant emotional and behavioral needs. The organizational culture can be affected by stressors as well, including budgetary pressures, complex regulatory requirements, negative social perspectives regarding the therapeutic work, and negative political pressures. These organizational level stressors can cause a therapeutic program to become "reactive, change-resistant, hierarchical, coercive, and punitive," thus "exhibiting symptoms of trauma similar to those of their clients", and creating a "traumatized culture" (Bloom & Sreedhar, 2008, p. 49).

In creating a healing and trauma-informed culture of intervention, the Sanctuary Model outlines seven characteristics for organizational change: culture of nonviolence, culture of emotional intelligence, culture of social learning, culture of shared governance, culture of open communication, culture of responsibility, and culture of growth and change. The model also includes the "S.E.L.F" treatment framework that outlines critical tasks needed to facilitate recovery from trauma: Safety, Emotional management, Loss, and Future. The components represent the four conceptual domains of disruption that can occur in a person's life and the associated areas of problem solving. The S.E.L.F framework "guides assessment, treatment planning, individual and team discussions, and psychoeducational group work" (Bloom & Sreedhar, 2008, p. 52). There are often inherent tensions between clinical or administrative staff in residential treatment centers, and the Sanctuary Model attempts to address these issues. For example, while the clinical or administrative staff often see the front-line "milieu" staff as extremely important, the milieu staff often feel powerless in the decision making process, especially decisions regarding setting limits on aggressive behavior. Often the clinical or administrative staff believes that the milieu staff prefer behavior control approaches and coercive tactics to maintain safety, while the milieu staff often think the clinical or administrative staff prefer policies that are too permissive (Abramovitz & Bloom, 2003).

The Sanctuary Model has been widely used in inpatient and residential programs (Ford & Blaustein, 2013). Elwyn, Esaki and Smith (2017) described their findings of a Sanctuary Model implementation in a girls' juvenile justice secure treatment that was characterized by frequent assaults on staff, restraint-holds, and high levels of fear for safety for all involved. After two years of implementing

the Sanctuary Model, meaningful improvements in safety, staff attitudes and relationships, atmosphere, accountability, relationships with residents, leadership, and employee engagement were realized. One of the primary factors of success was attributed to the attitude of the program manager, who role-modeled professional behaviors for staff and residents. The authors also pointed that another contributing factor was a natural (and difficult) staff turnover that occurred during the Sanctuary Model implementation. Staff that was not comfortable with the cultural change left the organization. Subsequent hiring decisions for replacements were based partially on the general acceptance of the Sanctuary Model therapeutic approach.

*The TARGET Model:* TARGET is an acronym that stands for "Trauma Adaptive Recovery Group Education and Therapy" (Ford & Russo, 2006) and has been adapted for use in juvenile justice settings. The TARGET model specifically addresses common challenges found in juvenile justice facilities that provide services to trauma affected youth—limited professional mental health staff or limited access to mental health practitioners, and the fact that many proprietary trauma interventions require a mental health professional deliver the service (Ford & Hawke, 2012). The TARGET model is designed to be delivered by staff with little mental health training, or by staff who are trained in mental health delivery, or by mental health professionals.

The TARGET model is a manualized gender specific treatment and intervention for trauma affected youth or adults that addresses emotional dysregulation responses to stressors caused by previous trauma exposure. An example of emotional dysregulation is emotional numbing, which is a common symptom in youth who have been exposed to trauma (Litz & Gray, 2002). Emotional numbing is correlated with higher rates of depression, anxiety, substance abuse, and unhealthy anger management practices. The TARGET model includes a seven-step skill acquisition sequence designed to address processing and managing trauma related reactions to current stressors (Ford & Hawke, 2012). The skills are summarized by the acronym FREEDOM which categorizes the skills as "self-regulation via focusing (F); trauma processing via recognizing current triggers, emotions, and cognitive evaluations (REE); and strength based reintegration by defining core values by making positive contributions (DOM)" (Ford & Hawke, 2012, pp. 371-372).

The TARGET model has not been widely tested in juvenile justice settings. In 2008 Frisman, Ford, Lin, Mallon, and Chang reported on their randomized trial of a group intervention for co-occurring substance abuse and traumatic stress disorders in adults. In a sample of 213 adults spread across three out-patient clinics, Frisman et al. found that compared with treatment as usual, the TARGET treatment groups had higher rates of sobriety six and 12 months post treatment. In one of the few studies related to juvenile justice settings, Marrow, Knudsen, Olafson, and Bucher (2012) completed a non-randomized program evaluation of a TARGET intervention in a sample of 38 incarcerated youth. Compared to treatment as usual, the TARGET group demonstrated lower rates of depression, youth threats towards staff, use of physical restraints, and seclusion rates. Ford and Hawke (2012) discussed their findings of a matched comparison group of 197 youth in the Connecticut juvenile justice system. The researchers found that youth who received the TARGET intervention were less likely to have disciplinary incidents, and less seclusion time, compared to youth who did not receive the TARGET intervention. Although the TARGET intervention did not significantly affect recidivism rates six

months post treatment, the authors noted a meaningful decrease in recidivism immediately after the treatment.

The limited research that has been completed on the TARGET intervention has highlighted common fears from juvenile justice administrators and front-line staff, who are concerned that implementing a trauma informed treatment protocol will decrease their personal safety. Ford and Hawke (2012) discussed staff concerns that addressing trauma will increase behavior management problems, or will decrease their ability to use behavior management consequences in lieu of having to use a trauma-informed response. The authors offered a response to this concern by giving examples of how the TARGET intervention was useful for staff because it taught youth how to better manage their emotions. As a side benefit, the authors noted that many staff members found the TARGET principles useful in their own emotional regulation, and therefore were more confident in their abilities to positively address problematic behaviors from youth.

## FOUNDATIONS OF MENTAL HEALTH TREATMENT IN RESIDENTIAL SETTINGS

Given that most youth who come in contact with the juvenile justice system have a diagnosable behavioral health disorder (Shufelt & Cocozza, 2006; Teplin et al., 2013) it is important that mental health interventions are based on effective practices that are grounded in adolescent mental health theory. Mental health interventions should also recognize that youth involved in the juvenile justice system have higher rates of trauma exposure compared to their non-justice involved youth (National Center for Mental Health and Juvenile Justice Policy, 2016) and that trauma affected youth have unique needs. Studies have also shown that more than 60% of youth with a mental health disorder also have a substance use disorder (Shufelt & Cocozza, 2006). Mental health disorders in youth are generally more complex than in adults because adolescence is a time of developmental change, therefore youth are more susceptible to change and interruption (Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016). In addition, youth behaviors stemming from mental health and substance use issues present challenges for juvenile justice staff who experience stress, anxiety, and job-related burnout (Meservey & Skowyra, 2015) The challenge for mental health professionals and for staff working in the juvenile justice system is to implement empirically supported interventions and treatments that are specifically tailored to meet the complex needs of justice-involved youth. This review is intended to describe the general features of the literature regarding mental health treatment in the juvenile justice system in order to provide a broad context in which to examine best practices. Three intervention strategies or programs are examined: Cognitive Behavioral Therapy (CBT), Multisytemic Therapy (MST), and Functional Family Therapy (FFT). CBT is a general term used to describe a variety of interventions, while MST and FFT are both proprietary treatment programs.

*Therapeutic Alliance:* There is a generally agreed upon characteristic required for any treatment to achieve positive outcomes known as the working relationship, or therapeutic alliance. The working relationship between a therapist and client is also known as the therapeutic alliance, and it generally describes the quality of the relationship between therapist and client (Hurley, Lambert, Van Ryzin, Sullivan, & Stevens, 2013). More specifically, the therapeutic alliance has been characterized as having three parts: the bonding or affective components of the relationship, the shared understanding of the treatment plan, and agreement with the treatment goals (Bordin, 1979). Most of the research regarding therapeutic

alliance has been completed with adults, and less has been conducted with youth and adolescents. The adult oriented literature describes a strong relationship between therapeutic alliance, and client engagement and treatment outcomes (i.e. Horvath & Bedi, 2002), while the youth-oriented research focuses on the positive relationship between the youth and their therapist (Holmquist, Hill, & Lang, 2007; Hurley, Lambert, Gross, Thompson, & Farmer, 2013). Whatever terms are used to describe the relationship, it is clear that a healthy therapeutic alliance is a key component in an effective treatment milieu, especially in residential treatment settings (Hurley, Lambert, Gross, Thompson, & Farmer, 2013).

Youth participating in residential treatment programs often interact with multiple people during their treatment, including residential treatment staff that supervises daily living activities and therefore who generally have the most contact with the youth. In light of this large amount of interaction with the youth, the relationships between front-line staff and youth are arguably the most important in the treatment delivery (Dowden & Andrews, 2004). Staff members who exert warm, open and genuine communication have been shown to be more effective in developing therapeutic alliances that are characterized by mutual respect and liking between staff and youth (Lambert & Barley, 2001), although not all studies have found positive relationships between warmth and outcomes (Holmquist, Hill, & Lang, 2007).

*Legitimacy:* An argument can be made that these healthy and positive relationships can also contribute to the therapeutic milieu by increasing the perception of legitimacy—the concept where an individual perceives authorities as fair and just, and legal processes as valid (Cavanagh & Cauffman, 2015). Legitimization of the law and institutions is strongly related with positive outcomes, and therefore is an important component in residential treatment programs. Residential treatment program interactions that are characterized by healthy, open and understanding relationships between front-line staff and youth are more likely to foster a sense of legal legitimacy in the youth, and therefore encourage engagement and compliance with the treatment regime. Individuals who believe they are receiving fair treatment are more obligated to obey requests, and exhibit law abiding behavior. As the perceived level of legitimacy decreases, youth are more likely feel justified in breaking the rules that are being forced upon them by an unjust system (Fagan & Piquero, 2007). There are four components to the perception of procedural fairness in adults (and it could be argued the same for youth): the degree to which opinions and concerns can be voiced, the neutrality and contingent manner in which decisions are made, the politeness and respectfulness of their interpersonal relationships with authority figures, and the degree to which they believe authority figures are acting with benevolent and caring motives (Tyler, 1990).

## COGNITIVE BEHAVIORAL THERAPY (CBT)

CBT is a widely used and studied approach to treatment in the overall criminal justice system, and in the juvenile justice system specifically (Developmental Service Group, 2010). Guadiano (2013) reported there "are now over 325 clinical trials of CBT for various clinical populations, including mood disorders, anxiety disorders, marital distress, anger , childhood disorders, and chronic pain" (p.5). Supporters point to CBT's goal-oriented and problem focused approach that allows for easy measurements of effectiveness. The goals of CBT are observable—changed behavior—and therefore can be easily quantifiable. CBT results are typically realized fairly quickly, especially if the person is amenable to change

(Developmental Service Group, 2010). CBT is a broad term that includes a variety of intervention therapies, with the basic premise that the way a person thinks affects their behavior (Bogestad, Kettler, & Hagan, 2010). Beck (1976) was a pioneer in exploring the idea of negative cognition and its relationship with depression and since then, a multitude of studies have been completed that supports the general scientific approach of CBT to addressing psychological disorders.

*Empirical Evidence:* There is evidence supporting the effectiveness of CBT for justice-involved youth with mental health issues (Development Services Group, 2017). There are two primary components of CBT: Cognitive therapy is directed at changing a person's thoughts, assumptions and beliefs in an effort to change maladaptive thinking patterns and habits (Development Services Group, 2010); Behavioral therapy relies on replacing negative behaviors with positive behaviors through a process of critical analysis and consistent exploration of desired outcomes and positive life goals (Jackson, Nissenson, & Cloitre, 2009).

From a cognitive perspective, psychological problems result from faulty thinking patterns that have been developed over a person's lifetime. A person's incorrect thinking is a result of inadequate or incorrect information (Hansen, 2008). From a behaviorist perspective, human behavior is a result of learned behavior, and that negative or undesirable behaviors can be unlearned.

Many readers will recognize Skinner's contribution to modern behavioral therapy with his operant conditioning experiments that led him to conclude that human behavior can be modified through the use of positive or negative reinforcers. The use of token economies juvenile justice setting is an example of a behaviorist perspective put into practice—participants earn points for positive behavior and lose points for negative behaviors. Accumulated points can be exchanged for items that the person perceives as having value, such as food or candy, or additional free-time (Ivy, Meindl, Overley, & Robson, 2017). A closer review of token economies is provided below in this literature review.

*Criticisms of CBT:* CBT has attracted criticisms from outside the CBT community and also within the CBT community and it is worthwhile to note these as the juvenile justice system attempts to balance public expectations of community safety, accountability, and rehabilitation with needs of the individual juvenile justice involved youth (Roush, 2008). Outside critics of CBT point to its mechanistic approach and a failure to fully address concerns of the whole person. Inside critics of CBT point to evidence supporting the idea that the cognitive portion of the treatment protocol does not contribute to the overall treatment effects—that is, a stripped down model emphasizing behavioral interventions has shown promise (Gaudiano, 2013).

Interestingly, while there is a robust literature demonstrating the effectiveness of CBT for a variety of issues, there is emerging evidence suggesting the causal relationships between dysfunctional attitudes and treatment outcomes are not empirically supported. For example, Burns and Spangler (2001) failed to confirm any of the predicted causal relationships between thinking errors and treatment outcomes in a sample of 521 patients receiving CBT, leading the researchers to question the basic premise of CBT. While this is just one study and therefore should not be overgeneralized, there are a number of alternative therapies being developed based on the latest research, including Dialectical Behavior Therapy (DBT), and Acceptance and Commitment Therapy (ACT), both of which attempt to balance the acceptance

and change-based strategies put forth by traditional CBT (Gaudiano, 2013). In summary, the evidence base of CBT is extensive, and there is a need for more research with specific problems and specific populations, such as youth of color and girls within in the juvenile justice system.

## MULTISYSTEMIC THERAPY (MST)

MST is a proprietary treatment that is empirically supported by numerous studies demonstrating effectiveness in juvenile justice populations, and is listed as a "Model Plus" evidence-based program by Blueprints for Healthy Youth Development (2018). MST is widely recognized as an effective evidence-based intervention by many federal agencies including U.S. National Institute on Drug Abuse (NIDA), National Institute on Mental Health (NIMH), the Surgeon General's office, Center for Substance Abuse Prevention, Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Annie E. Casey Foundation (Littell, 2005). According to the developers, there are now more than 2,500 MST clinicians in 15 countries, and in 34 states in the U.S., and more than 200,000 youth have been served (MST Services, n.d.).

MST is an intensive family and home-based intervention that attempts to decrease barriers to treatment, and to increase engagement in treatment (Sheidow, Henggeler, & Schoenwald, 2004). MST is delivered by master-level therapists who carry a small caseload (four to six families) and make themselves available 24 hours a day, seven days per week to their clients so that problems can be immediately addressed. Services are provided in the home, school, or community at times convenient for families. Treatment duration is typically limited to four to six months, and clinical fidelity is maintained by doctoral level or advanced master level supervisors (Blueprints for Healthy Development, 2019; Sheidow, Henggeler, & Schoenwald, 2004). The treatment goal is to empower families to effectively manage the challenging behaviors of their adolescents and to strengthen family coping skills to address future potential problems. MST practice rests on nine core principles that guide the therapist's work with youth and families: Finding the Fit, Positive and Strength-Focused, Increasing Responsibility, Present-focused/Action Oriented/Well Defined, Targeting Sequences, Developmentally Appropriate, Continuous Effort, Evaluation/Accountability, and Generalization (Blueprints for Healthy Development, 2019; Sheidow, Henggeler, & Schoenwald, 2004).

*Grounded in Systems Theory:* The general premise of MST is grounded in systems theory (von Bertalanfffy, 1968) and Bronfenbrenner's theory of social ecology (Bronfenbrenner, 1979). The systems framework views adolescent behavior as a continuous and iterative relationship between the individual, family, peers, school, community and the larger culture in which the youth resides. In other words, an individual is an active participant in their behavior and their behavior is affected by a give and take relationship with their family, friends, school, community and macro-level cultural forces. This perspective also assumes that proximal systems have more effect on an adolescent's behavior than more distal systems. For example, effects of family, friends, and school are assumed to be more influential (Sheidow, Henggeler, & Schoenwald, 2004).

*Criticisms of MST:* There are concerns about the scientific validity of the MST literature. At first glance, the literature concerning MST is extensive and strongly supportive of its effectiveness in improving outcomes for a variety of issues including youth violence and criminal behavior, alcohol and drug abuse, serious emotional disturbance, juvenile sex offending, and child maltreatment

(Sheidow, Henggeler, & Schoenwald, 2004). However, several researchers have noted deficiencies in the literature that are worth mentioning. In 2009, Littrell and colleagues published a systematic review of 266 MST evaluations from 1985 to 2003. They reported that most of the studies were conducted by the MST developers, and that of the eight studies that met their inclusion criteria, none showed any differences between MST and treatment as usual (Littrell, Campbell, Green, & Toewe, 2009). In 2006, in a response to strong pushback from the MST developers, Littrell wrote "it is premature to draw firm conclusions about the effectiveness of MST—one way or the other" (p. 469). In 2018, Markham published the results of a review of 11 MST studies completed between 2006 and 2014, and concluded the results of MST "continue to be mixed across studies" (p. 67).

*Summary of MST Literature:* In summary, MST is a widely used and accepted proprietary treatment for youth and their families, and its effectiveness has been supported by a number of studies, although most of the studies have been conducted by the MST developers which has raised concerns about the need for additional independent evaluations that are based on pure scientific inquiry—that is, questions remain about the replicability of MST.

## FUNCTIONAL FAMILY THERAPY

Functional Family Therapy is a proprietary short-term treatment program originally developed in the 1980s as an intervention for families experiencing adolescents with disruptive behavior problems (Robbins, Alexander, Turner, & Hollmon, 2016). FFT integrates systems theory with cognitive behavioral theories in a combination to address a range of negative adolescent behaviors. Since its inception, FFT has been reviewed numerous times and has been identified by Blueprints for Healthy Youth Development as a Model program (Blueprints for Healthy Youth Development, 2019) and is widely used to treat juvenile justice involved youth and their families. The development of FFT into an evidence-based juvenile justice practice has evolved over the past 40 years as a result of "interplay between theory, research and practice" (Robbins, Alexander, Turner, & Hollmon, 2016, p. 543). FFT has been disseminated in more than 300 communities in the U.S., and in four international settings (Sexton & Turner, 2010).

*Description of FFT:* A typical FFT intervention has 12 – 14 1-hour weekly family sessions that takes place in the home, and in the office. FFT is delivered in five phases: Engagement, Motivation, Relational Assessment, Behavior Change, and Generalization (Robbins, Alexander, Turner, & Hollmon, 2016). FFT is normally implemented with three to eight master level therapists who carry a caseload of 10 to 12 families and are supervised by a licensed clinical therapist (Blueprints for Healthy Youth Development, 2019). FFT is based on family theory which posits the family is a primary factor in the prosocial development of children, youth and young adults (Development Services Group, 2014). In this way, FFT differs slightly from MST in that FFT is based more securely on theories that recognize families as distinct systems in and of themselves, whereas MST incorporates systems theory and social ecology theories that recognize the interplay with external forces and influences.

## OPTIMAL LENGTH OF STAY

The literature regarding optimal length of stay for juvenile justice involved youth in residential treatment centers is incomplete. Most of the research on youth in residential treatment centers has focused on child-welfare settings and out of home placements resulting from abuse and

neglect such as foster care. Much less is known about residential treatment outcomes for youth involved in the juvenile justice system, and what is known has been extrapolated from the child welfare system. To be sure, there are valid connections and overlaps between these two systems, but it is important to note the deficiencies in the juvenile justice literature.

*Gaps in the Literature:* The lack of evidence regarding the effects of length of stay on outcomes for juvenile justice involved youth is concerning given the fact that in 2015, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) reported that 48,043 juvenile justice involved youth were placed in residential treatment programs. Most of the youth were male (about 70%). The average length of stay for all youth was 113 days, with 32% of committed youth (non-detained) remaining in residential treatment after six months (OJJDP, 2018). There were no differences in length of residential placement between white and minority youth. (OJJDP, 2018).

*Forces Affecting Length of Stay:* There are two ideologies that inform the optimal length of stay. One is based on economics, which are somewhat quantifiable, and the other is based on rather anecdotal evidence suggesting that optimal improvements in youth behavior occur magically at the six month mark. The economic school of thought is that residential treatment is a very expensive intervention, and shorter lengths of stays are therefore less expensive.

*Economics:* Residential care is inherently high cost because of the 24-hour staffing required, the costs of mental health interventions, and the costs associated with taking care of youth around the clock (food, clothing, shelter, activities). Most of the arguments to reduce the length of stay are centered on the costs of providing the residential treatment, which is problematic because of the lack of attention to outcomes (Huefner, Ringle, Thompson, & Wilson, 2018). While there is strong agreement that juvenile justice involved youth arrive at residential treatment with a variety of factors that puts them at risk for negative life outcomes (education, relationships, physical and mental health, criminal behaviors), there is a surprising lack of knowledge about the cost benefit features of residential treatment. That is, residential treatment is expensive, but few studies have examined costs in light of the potential long term benefits to the youth, their families, and their communities.

*Duration "Sweet Spot":* There is a thin and rapidly aging thread in the literature that supports the idea that shorter duration stays are correlated to better outcomes, and that a six month length of stay is some sort of meaningful treatment duration. For example, Hoagwood and Cunningham (1992) found that positive changes in youth behavior occurs during the first six months of residential treatment in a behavioral health setting—not a juvenile justice setting. Shapiro, Welker, and Pierce (1999) found that in a sample of 27 youth participating in a state agency residential treatment program for youth with extreme behaviors and emotional problems, almost all of the improvements occurred in the first six months of treatment.

The only study that was found in the literature that examined relationships between length of stay and outcomes (as measured by recidivism) was completed by Traynelis-Yurek and Giacobbe in 1988, and it offered contrasting evidence. The study investigated the effects of age and length of stay on recidivism on a sample of 228 boys who participated in a multi-faceted treatment program in Virginia, operated by a private nonprofit agency licensed by the Virginia Department of Education to serve emotionally disturbed or learning disabled young men. Most of the boys were involved in the juvenile justice

system. Traynelis-Yurek found that longer stays and older age at time of release were correlated with lower recidivism rates.

*Summary:* It is understandable why economic pressures would tend to encourage shorter length of stays in residential treatment as opposed to longer, but there are few studies that have examined the effect of length of stay (independent variable) on outcomes (dependent variables), and even fewer have considered juvenile justice involved youth. It is obvious that much more research is needed to determine the relationships between length of stay and youth outcomes before any conclusions may be drawn.

## RESIDENTIAL TREATMENT PROGRAMS FOR GIRLS

The field of residential treatment programs for girls is characterized by two important features: a wide acceptance and interest in the need to develop gender specific programs, and a dismal lack of empirical evidence supporting these efforts. The increase in the number of girls involved in the juvenile justice system, and a recognition of their gender specific developmental pathways into the system, has sparked intense interest in developing residential treatment programs to meet the needs of girls (Day, Zahn, & Tichavsky, 2015; Walker, Muno, & Sullivan-Colglazier, 2015; Zahn et al., 2010). At the same time, there is a surprising lack of evidence supporting gender-specific residential treatment programs for girls involved in the juvenile justice system (Kerig & Schindler, 2013).

This is concerning for several reasons. One is that the knowledge regarding the different developmental processes between girls and boys and their entry into the juvenile justice system is well developed (Zahn, Day, Mihalic, & Tichavsky, 2009; Matthews & Hubbard, 2008; McCabe, Lansing, Garland & Hough, 2002; OJJDP, 2010). The other reason is from a policy perspective and a 30 year old recognition that there needs to be more gender specific programs for girls. Congress recognized the need for gender specific programming for girls by the passing of the Juvenile Justice and Delinquency Prevention Act in 1992. In 1998 the Office of Juvenile Justice and Delinquency Prevention (OJJDP) reissued recommendations for gender specific interventions that met the needs of girls.

In 2004, OJJDP initiated the Girls Study Group and reviewed the existing literature on girls in the juvenile justice system and concluded there was a lack of longitudinal gender specific outcome data and that many of the outcome studies used nonscientific research designs that relied on small non-representative samples. Thus, there has been a clear understanding about the unique needs of girls in the juvenile justice system which has been supported by the highest juvenile justice policy making body in the U.S., and yet the empirical evidence about what works for girls is severely lacking not only in the juvenile justice system as a whole, but more specifically within the realm of residential treatment.

This is not to say there are no gender specific residential treatment centers for girls. On the contrary—a quick online search reveals a plethora of residential treatment programs that claim to address the unique needs of girls. But there is scant evidence in the research literature that supports the effectiveness of these programs.

- *Program Characteristics:* Science has informed gender specific residential treatment programs for girls, and there are well supported recommendations for program components that are based on meeting the known developmental risk and resiliency factors for girls in the juvenile justice system. These are generally seen

as general recommendations for all juvenile justice involved girls (not specifically residential treatment). For example, Sherman (2005) produced a list of program characteristics that address the needs of girls in the juvenile justice system:

- Comprehensive (integrate family and community systems)
- Safe (promote healing from trauma), 3. Empowering (encourage leadership and the development of strengths)
- Relational (ongoing support, positive adult relationships with older women)
- Community and family-focused (community-based, positive family relationships, and sustainable community connections).

Researchers have confirmed other general program characteristics required to meet the needs of girls: respect, empathy, safety, agency, and privacy (Bloom & Covington, 2003; Ravoira, Granziano, & Patino Lydia, 2012).

Finally, there is a recognition that while girls have different developmental pathways into the juvenile justice system compared to boys on the average, there is a heterogeneity of risks and needs within the female population of juvenile justice involved youth (Bright, Kohl, & Jonson-Reid, 2014) and that the most effective interventions should be individualized as much as possible to avoid a one-size-fits-all approach (Walker, Muno, & Sullivan-Colglazier, 2015).

## POINT-LEVEL SYSTEMS AND TOKEN ECONOMIES

The literature on token economies and their use in juvenile justice residential treatment settings is extensive and describes an evolution of practice beginning in the early 1960s with increasing use up until the early 2000s when the practice began to fall out of favor (Boerke & Reitman, 2011; Ivy, Meindl, Overley, & Robson, 2017; Mohr, Martin, Olson, Pumariega, & Branca, 2009; VanderVen, 2009; Tompkins-Rosenblatt & VanderVen, 2005).

The theoretical foundation of token economies comes from Skinner's early work (1953) on human behavior based on contingency relations (antecedents, behaviors, consequences) (Boerke & Reitman, 2011). Token economies have been used in many settings, including schools, business, in-patient psychiatric hospitals, and corrections (Boerke & Reitman 2011; Ivy et al., 2017).

*Definition:* In simple terms, a token economy is a behavioral management system that uses rewards for desired behavior and penalties for undesired behavior with the expectation that the person subjected to the token economy will change their behaviors to align more closely with the desired behaviors (Ivy, et al., 2017).

People earn tokens, or points for good behavior that are used to "purchase" various items that are perceived to be of value. In juvenile justice settings, token economies are often referred to as point-level systems (Mohr et al., 2009) where youth can advance upward through various levels earning more points and privileges along the way. Youth entering a program usually start in the lowest level on which they have the fewest privileges (VanderVen, 2000).

Front-line staff can award points to youth for good behavior, freeze, suspend or reduce points for undesired behaviors. Often progress in residential treatment programs is quantified in part by a youth's advancement through a point-level system (Mohr et al., 2009). If a youth is court mandated to successfully complete a residential treatment program, the progress (or lack of progress) through a point-level system can have significant

effects on how the court decides future dispositions for that youth. Therefore, it is important to understand the criticisms of point-level systems and the growing body of literature that suggests point-level systems are inappropriate for juvenile justice involved youth.

*Criticisms:* Criticisms of using token economies in juvenile justice settings are characterized by an overarching main point: the treatment effects of behavior modification interventions based upon token economies (vis a vis point-level systems) do not persist after treatment is withdrawn. There are several supporting viewpoints: point-level systems do not encourage individualized treatment, point-level systems are not developmentally, culturally or cognitively appropriate, point-level systems are often administered non uniformly by front-line staff, point-level systems rely on external control practices, and youth should not have to earn their treatment (Tompkins-Rosenblatt & VanderVen, 2005; Mohr & Pumariega, 2004; VanderVen, 2000, 2003, 2009).

*Short-term effects:* Critics point out that overall; point-level systems do not work for juvenile justice involved youth receiving behavioral modification residential treatment because the treatment effects are short-lived (Mohr et al., 2009). There are many suspected reasons for short-term effects of point-level intervention. Kazdin (1996), an early describer of token economies, noted that the behaviors and skills learned via a point-level system often do not translate well to the youth's ecological systems outside the treatment milieu. In other words, youth might figure out how to successfully navigate a point-level system to earn privileges and advance through treatment but upon returning to the community, negative behaviors can reestablish. Residential treatment environments are usually highly controlled and are very different to a youth's family, friends, school and community environments (Mohr & Pumariega, 2004). Mohr, et al. (2009) described this as a problem of generalizability to a youth's natural environments (ecological validity). Weaver wrote about this nearly 30 years ago—institutional compliance does not equate to successful reintegration in the community (Weaver, 1990).

*Point-level systems do not encourage individualized treatment:* One of the fundamental intervention philosophies of the juvenile justice system is Responsivity (Ward, Messler, & Yates, 2007). The Responsivity approach to juvenile justice involved youth requires treatment to be individualized to meet the particular youth's age, developmental stage, race, gender, learning ability, and level of motivation for change (Rocque, Welsh, Greenwood, & King, 2014). Mohr and Pumariega (2004) stated " Interventions and treatments are bound to fail when they are not developed on the basis of individuals' development and are not sensitive to their various cognitive, social, and emotional domains and needs (p.119). Simply put, point-level systems do not allow for individual adaptations to allow for a youth's cognitive or developmental stage (Mohr et al., 2009), or for a youth's cultural group (VanderVen, 2000) and therefore are in conflict with the Responsivity principle.

*Point-level systems are not developmentally, culturally or cognitively appropriate:* It is widely recognized that juvenile justice involved youth are not a homogeneous group—youth come in contact with the system having a variety of developmental, cultural and cognitive needs. Critics of point-level systems point out that because point-level systems are a one-size-fits-all approach, they often assume that the same behavioral modification stimuli operates the same for all youth, no matter their gender, race, socioeconomic status, culture, cognitive skills, family structure, family functioning, family traditions,

etc. (Bredekamp & Rosegrant, 1992; Mohr et al., 2009; Mohr & Pumariega, 2004). Youth in residential behavioral modification programs are there typically because they have problems with impulsivity, affect regulation, and behavior control, and these characteristics have facilitated their involvement with the juvenile justice system.

Often these behaviors are related to previous exposure to trauma. Therefore, point-level systems that effectively punish youth for behaviors that have an underlying cause are not developmentally or cognitively appropriate. VanderVen (2000) described "normalization" as an important component to appropriate interventions which is applicable to this discussion. Normalization simply refers to the therapeutic approach of treating a person in a way that encourages normal or desired behaviors (Wolfensberger, 1972). Point-Level systems can treat youth in non-normal ways in that they force youth to earn privileges that are normally associated with typical living comforts (i.e. phone calls with family, food items), youth must earn their relationship with staff instead of receiving unconditional therapeutic support, and youth must earn the right to participate in activities that encourage prosocial behaviors (i.e. community outings, sporting events, watching TV). Rauktis's (2016) qualitative study of child-welfare involved youth in residential treatment found that point-level systems sometimes worked at cross purposes with treatment goals, with youth being denied opportunities to practice independent living skills because their levels prohibited participating in certain activities such as group treatment sessions, community field trips, and family visits.

*Point-level systems are often administered non uniformly by front-line staff:* This criticism is not necessarily aimed at individual staff members overtly biased or purposefully unfair administration of a point-level system, but more to the point that residential treatment centers have multiple shifts and numerous staff coming and going who might administer the point-level system inconsistently across shifts (Mohr et al., 2009).

The reasons for non-uniform application of point-level systems are varied. Front line staff might not be fully trained on the delicate balance required between reinforcers and negative consequences in order to encourage desired behaviors. For example, there is supporting evidence that for every negative consequence, there should be four positive reinforcers (Friman, Jones, Smith, Daly, & Larzelere, 1997). This ratio might be difficult to maintain across multiple staff working different shifts, each with their own knowledge of the theory of point-level systems, and each with their own relationships with the youth in treatment and each with their own frustration tolerance (Mohr et al., 2009). Rautkis (2016) highlighted instances when youth perceived staff using point-level systems to exert power and control over them instead of serving their treatment needs.

*Natural versus Imposed Consequences:* Mohr et al. (2009) discussed the lack of training for front-line staff regarding the differences between natural consequences (what happens naturally if the behavior continues) and imposed consequences (punishment). It is generally thought that natural consequences have higher value in the overall treatment plan because youth begin to develop autonomy in their decision making, thus leading to durable behavior change over time. If front-line staff is not thoroughly familiar with the differences between natural and imposed consequences, they might administer a point-level system non uniformly, or worse, in ways that work against positive treatment outcomes (Mohr et al., 2009).

*Point-level systems rely on external control practices:* Psychological research in the past 50 years has established

that a person's ability to develop autonomy (self-control) is strongly related to their motivation to change, which in turn is strongly related to treatment outcomes (Kohn, 1993; Norcross & Hill, 2004). One criticism of point-level systems is that they rely heavily on external control and therefore can work at cross purposes with widely accepted treatment practices (Mohr et al., 2009; VanderVen, 2000).

The adolescent treatment literature also discusses the benefits of a "therapeutic milieu" that incorporates a therapeutic alliance (the quality and strength of the relationship between client and therapist) and empathy (the therapist's ability to understand the client's thoughts and feelings). While front-line staff are not typically licensed therapists, they usually have the most contact with youth in residential treatment and therefore the relationships between staff and youth are important to consider in the larger context of treatment outcomes (Braxton, 1995; Mohr & Pumariega, 2004).

Many juvenile justice involved youth arrive at mandated residential treatment with a long history of disrupted relationships with adults and peers. Point-level systems can perpetuate distrust and disassociation if youth perceive front line staff as arbitrary administers of rewards and punishments (VanderVen, 2009). Bernstein (2014) emphasized "rehabilitation happens in the context of relationship" (p. 259) and there is considerable evidence that point-level systems inherently undermine healthy relationships between youth and adults responsible for their development in residential treatment. Point-level systems might control in the short-term, but could have negative effects on long-term sustainable positive change for juvenile justice involved youth.

*Youth should not have to earn their treatment:* Critics of point-level systems highlight significant ethical concerns with the practice. Creating a therapeutic alliance is a central tenant of best practice, and is dependent on developing a youth-adult helping relationship that encourages autonomy and decision-making (Rautkis, 2016).

Additionally, developing skills that are transferable and generalizable to a youth's family and community environment is an important treatment goal for juvenile justice involved youth in residential treatment (VanderVen, 2000). Caring, positive, and empathetic adults are the foundational pillar of positive relations and access to such adults should be unconditional. Access should not be affected by a youth's performance in a point-level system (VanderVen, 2009).

Treatment goals typically include helping youth build strengths and skills to encourage healthy development, and healthy relationships with adults is a key element in that process. If youth participating in a mandatory point-level system perceive adults as anything less than unconditionally fair, the potential for long term positive outcomes are diminished (Mohr et al., 2009; Rautkis, 2016; VanderVen, 2000, 2009).

## SUBSTANCE USE DISORDER (SUDS) TREATMENT

The literature regarding SUDS treatment for youth in the juvenile justice system can be described as having three primary features: 1) the arrest rates for drug and alcohol law violations have steadily declined in the past decade and are currently at historically low levels, 2) juvenile justice involved youth have higher rates of SUDS compared to non-juvenile justice involved youth and SUDS are correlated with increased criminal behaviors, 3) there are a wide variety of treatment modalities for juvenile justice involved youth with SUDS, and there is considerable overlap between these treatments, including

overlap with mental health treatments.

*Recent Trends:* The juvenile arrest rate for drug and alcohol law violations in 2016 (the latest data available) was at the lowest levels since the 1990s, with 139,970 youth ages 10 – 17 years of age arrested for drug and alcohol law violations. This represented 16.3% of the total 856,130 youth arrested in 2016 (OJJDP, 2018). While these trends are promising, it is important to recognize the impacts of drug use on youth, families, communities and the juvenile court. For example, in 2016, drug cases accounted for 13% of the total cases handled by the juvenile court. About 27% of those cases were dismissed, 49% resulted in informal sanctions (fines, restitution, community service, referrals for additional services) and 25% resulted in formal sanctions (out of home placement, waiver to criminal court, or formal probation). Eighteen percent of cases involving drug law violations resulted in predisposition detention (Hockenberry & Puzzanchera, 2018).

*High Rates of SUDS Associated with Increased Criminaltiy:* There is strong evidence that youth deeply involved in the juvenile justice system have high rates of SUDS compared to their lessor involved companions, and that higher rates of SUDS are associated with increased severity of criminal behavior. For example, in a sample of 1,829 detained youth, nearly 50% of males and 45% of females had one or more SUDS, and nearly a quarter of males and females had two or more SUDS (McClelland, Elkington, Teplin, & Abram, 2004). Multiple SUDS are related to unhealthy life outcomes for youth, including serious and violent offending, aggression, and suicide (Loeber & Farrington, 1998; 2001; Tripodi, Springer, & Corcoran, 2007). Higher rates of substance use are found in incarcerated and violent juvenile offenders compared with less serious juvenile offenders (Tripodi, Springer, & Corcoran, 2007). Loeber and Farrington (1998) reported that on average, serious and violent juvenile offenders use substances more often and more frequently compared to less serious offending juveniles. Finally, juvenile justice involved youth with SUDS are more likely to have comorbid mental health disorders (Young, Dembo, & Henderson, 2007), which are associated with diminished outcomes.

*Wide Variety of SUDS Interventions:* There is a wide variety of drug abuse interventions and related treatments offered to youth in the juvenile justice system, and these interventions and treatments are vaguely related to the 13 "Principles of Drug Abuse Treatment for Criminal Justice Populations" (National Institute on Drug Abuse, 2014). The National Institute on Drug Abuse (NIDA) (2014) outlined 13 principles of drug abuse treatment for adults in the criminal justice system and there commonalities between these and common SUDS treatment components in the juvenile justice system, although there is a scarcity of discussion in the literature about the empirical overlaps between the adult criminal justice system and the juvenile justice system. The 13 Principles of Drug Abuse Treatment for Criminal Justice Populations are:

- Drug addiction is a brain disease that affects behavior
- Recovery from drug addiction requires effective treatment, followed by management of the problem over time
- Treatment must last long enough to produce stable behavioral changes
- Assessment is the first step in treatment
- Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations
- Drug use during treatment should be carefully

monitored

- Treatment should target factors that are associated with criminal behavior
- Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements
- Continuity of care is essential for drug abusers re-entering the community
- A balance of rewards and sanctions encourages pro-social behavior and treatment participation
- Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach
- Medications are an important part of treatment for many drug abusing offenders
- Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis (NIDA, 2014)

Many of the 13 principles are represented in juvenile justice SUDS treatment approaches, but there are no direct comparisons or discussions in the literature regarding the appropriateness of applying adult-oriented treatment strategies to juveniles.

In the latest national survey of substance abuse treatments for juvenile justice involved youth, Young, Dembo, and Henderson (2007) compiled the results from 141 juvenile facilities including Residential Treatment Centers (RTCs). There were a wide variety of treatments offered, and the components and intensity of the treatments varied across settings. In the 49 RTCs included in the survey, the most common treatment modality was a brief (1 – 4 hours) weekly substance abuse group counseling (50.7%). A smaller percentage (42.2%) reported more intensive substance abuse group counseling of 5 to 25 hours per week (Young, Dembo, & Henderson, 2007). The survey also documented large percentages of youth in RTCs with access to ancillary services including HIV/AIDS testing (64.3%), HIV/AIDS counseling and treatment (55.9%), TB screening (93.7%), hepatitis C screening (73.5%), physical health services (97.0%), mental health assessment (96.2%), assessment for co-occurring disorders (77.2%), counseling for co-occurring disorders (64.4%), family therapy (46.0%), domestic violence intervention (35.7%), life skills management (81.5%), and cognitive skills development (90.8%).

*Juvenile drug courts:* While not a SUDS intervention per se, one of the most popular interventions for juvenile justice involved youth who have substance abuse issues are juvenile drug courts. Juvenile drug courts are specialized dockets that provide services for youth with SUDS and who have a high risk of reoffending (Nissen & Pearce, 2011).

The goal of the juvenile drug court is to provide support and accountability for youth with SUDS as they complete substance abuse treatment and community reintegration (Yelderman, 2010). There is not a clear definition of what a juvenile drug court is, but there is general agreement that they are characterized by higher intensity supervision that allows for the court to interact more frequently with youth and their families so that incentives and sanctions can be administered quickly and appropriately. More frequent drug testing via urinalysis is a key feature of most juvenile drug courts (Long & Sullivan, 2017).

Juvenile drug courts typically work with community-based

treatment providers to augment the level of intervention. Most juvenile drug court programs are nine to 12 months in duration and use a multi-tiered approach to address substance abuse, criminogenic risks, education requirements and family engagement (Nissen & Pearce 2011).

*Therapeutic Jurisprudence:* The underlying theories that support juvenile drug courts are well founded in the juvenile justice system framework of positive, strength-based interventions that are individualized to meet a youth's cognitive, emotional, and cultural characteristics (Nissen & Pearce, 2011), as well as the concept of "therapeutic jurisprudence." Therapeutic jurisprudence refers to the practice of upholding a client's legal rights while mandating treatment for the purpose of changing behavior (Long & Sullivan, 2017). The prevalence of juvenile drug courts has increased despite mixed evidence of effectiveness (Henggeler, McCart, Cunningham, & Chapman, 2012).

*Concerns:* Substantial evidence suggests that juvenile drug courts are effective in reducing recidivism, substance use, and increasing overall youth functioning, however the quality of scientific validity and reliability of studies varies widely (Henggeler, McCart, Cunningham, & Chapman, 2012; Long & Sullivan, 2017; Nissen & Pearce, 2011). There are also questions about some basic assumptions of juvenile drug courts and whether their application of interventions that were developed for adults is appropriate or effective for youth. For example, many juvenile drug courts utilize sober support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) to provide youth with a community based support system. There are concerns that these adult sober support groups might not be appropriate for youth given their unique developmental needs that differ from adults (Borg, James-Andrews, van Wormer, Wheeler, & Yeres, 2010). Recent emphasis on the importance of evidence based practices in juvenile drug courts has also highlighted the need for more empirical research on the effectiveness of juvenile drug courts.

*Reclaiming Futures:* In 2000, the Robert Wood Johnson Foundation introduced the *Reclaiming Futures* initiative that involved in part, the juvenile drug court system. *Reclaiming Futures* is attempting to create an integrated care system that integrates a variety of juvenile justice reforms, including juvenile drug courts as well as detention reform, restorative justice, and disproportionate minority contact. The initial demonstration phase of *Reclaiming Futures* included 10 sites and has since grown to include 29 sites as of 2011. *Reclaiming Futures* has explored adolescent SUDS treatment, including innovations in screening, assessment, and treatment implementation (Nissen & Pearce, 2011).

Reclaiming Futures has a systems change perspective and has encouraged SUDS treatment to be evidence based, specifically developed for adolescents, and address cultural and identity factors for youth and their families (Nissen & Merrigan, 2011). The University of Arizona (2015) evaluated five Reclaiming Futures sites and found variation in drug court treatments. Two sites used the Adolescent Treatment Approach (A-CRA) model (Godley et al., 2001), two sites used The Seven Challenges program, and the other sites used a variety of other combinations. The A-CRA is an ecologically-based intervention that includes a youth's family, school, peers, employment and community in their treatment, and relies on positive reinforcement techniques (Godley, Hunter, Fernandez-Artamendi, Smith, Meyers, & Godley, 2014). The Seven Challenges approach is a proprietary intervention designed for youth and young adults with co-

occurring drug and mental health issues, trauma, and low family functioning. According to the California Evidence-Based Clearinghouse for Child Welfare (n.d.), The Seven Challenges is designed for youth and young adults with drug problems. The treatment addresses co-occurring life skill deficits and psychological problems. It should be noted that there are few published studies on The Seven Challenges in the academic literature.

*Juvenile Breaking the Cycle:* In 1998, the National Institute of Justice (NIJ) awarded Lane County (Oregon) Youth Services a grant to implement the program "Juvenile Breaking the Cycle" (JBTC). JBTC addressed the needs of substance abusing youth involved in the juvenile justice system through a combination of assessment and screening for drug abuse and related mental health issues, wrap-around coordinated services, and the use of sanctions and incentives designed to encourage youth to comply with treatment (Krebs, Lattimore, Cowell, & Graham, 2010). One component of JBTC was the juvenile drug court. An evaluation of Lane County's JBTC program found that youth participating in the drug court had mixed results compared to JBTC youth who did not participate in the drug court. While overall, the JBTC youth who participated in the drug court were less likely to recidivate compared to JBTC youth who did not participate in the drug court, JBTC minority males who participated in drug court were more likely to recidivate (Krebs, Lattimore, Cowell, & Graham, 2010).

*Intersections with other treatments:* A number of studies and reviews have examined specific SUDS treatment modalities for juvenile justice involved youth that intersect with several of the mental health treatments previously mentioned in this review. For example, Tripodi and Bender (2011) performed a literature review to assess the treatment effectiveness of SUDS treatment for alcohol and marijuana—two of the most used substances by teenagers. In their review, it was noted that more severe substance abuse is correlated with higher rates of criminality including violence. Ten studies that met their inclusion criteria of experimental or quasi-experimental were included, and the effect sizes compiled. All of the treatment interventions had a small to moderate effect size on treatment outcomes, with several interventions showing success. These included Multisystemic Therapy, Multidimensional Treatment Foster Care, Teaching Family, and Life Skills Training (Tripodi & Bender, 2011). Tanner-Smith, Steinka-Fry, Kettrey and Lipsey (2016) conducted an extensive literature search and located 61 experimental or quasi-experimental studies. With respect to the treatment-as-usual comparison groups, the researchers found that cognitive behavioral therapy, and family therapy had the strongest effects on treatment effectiveness.

*Summary:* In summary, juvenile justice involved youth with SUDS present challenging problems related to serious and violent criminal behavior. While the number of drug and alcohol related arrests have decreased during the past decade, a significant number of youth with SUDS and co-occurring conditions continue to present themselves to the juvenile court. A number of interventions have attempted to address the complex, ecological needs of youth with SUDS, including juvenile drug courts.

The evidence regarding the effectiveness of juvenile drug courts and other SUDS interventions is mixed, and continued evaluations are needed to determine the best ways to move forward in treating youth with SUDS. Finally, while there are clear underlying principles of treating adults in the criminal justice system, it is interesting that the literature contains little to no

discussion about the basic underlying principles of treating juvenile justice involved youth for SUDS.

## COLLABORATIVE PROBLEM SOLVING® (CPS)

Collaborative Problem Solving® (CPS) is a proprietary treatment intervention developed by Massachusetts General Hospital for use with children and teenagers with a range of emotional and behavioral challenges in a variety of settings including families, schools, foster care, inpatient psychiatric facilities, residential treatment facilities, and juvenile justice settings (www.thinkkids.org).

The state of Oregon recognizes CPS as an evidence based practice, and as such, a number of state of Oregon agencies have adopted CPS as part of the requirement to use evidenced-based programs for drug and alcohol treatment, some mental health treatment, adult recidivism prevention, and juvenile crime prevention as mandated by Oregon Senate Bill 267 (SB267) passed by the Oregon Legislature in 2003 (www.oregon.gov/oya/docs/SB267_2018.pdf). SB267 required 75% of state tax revenues spent on treatment by Oregon Department of Corrections, Oregon Youth Authority, Oregon Commission on Children and Families (changed to Community Based Service Hubs in 2013), Department of Human Services (portion that provides mental health and addiction services), and the Oregon Criminal Justice Commission, must be spent on "evidence-based programs." Other large non-governmental agencies have adopted CPS. For example, the Child and Adolescent Psychiatry Department at Doernbecher Children's Hospital located in Portland, Oregon is a Division of the Department of Psychiatry at Oregon Health Sciences University, and started adopting CPS in 2005.

*Basic Premise:* The basic premise of CPS is that children and youth will behave well if given the proper skills. The proprietors describe it in more simple terms: Skill not Will (www.thinkkids.org). That is, in most cases, children and youth don't lack the will to behave; they lack the skill(s) to behave. Traditional behavioral theories support the idea that children and youth learn disruptive behavior because those behaviors allow them to get something they want (e.g. attention) or allow them to avoid something they don't want (e.g. schoolwork) (Pollastri, Epstein, Heath, & Ablon, 2013).

These theories posit that children have control whether they are compliant or not with adult expectations—they will choose to do well if they want to. CPS takes a different approach and assumes that undesirable behaviors are a result from a lack of skills to behave in accordance with adult expectations. Advocates of CPS point out that many youth in the juvenile justice system have experienced multiple traumas that have affected their ability to manage impulse control, frustration tolerance, problem solving and other adaptive skills, and that these youth simply do not have control over whether they behave in accordance with adult expectations (Pollastri, Epstein, Heath, & Ablon, 2013). Therefore, if skills are improved, behavior will improve.

*Lack of Empirical Evidence:* With such widespread acceptance and an Oregon legislative mandate, it would be safe to assume that the empirical database demonstrating CPS's effectiveness is extensive, but surprisingly that is not the case. In fact, there is an alarming lack of peer-reviewed studies found in the academic literature regarding CPS. Even the proponents of CPS have documented the lack of empirical evidence regarding the program's effectiveness. For example, Pollastri, Epstien, Heath, and Ablon (2013) conducted a literature of CPS studies completed to date, and had to include a number of unpublished studies and

evaluations in order to increase the number of studies in their review. They reviewed six published studies in a variety of settings including outpatient family therapy, inpatient psychiatric, outpatient therapy, and an alternative day school. One of the studies employed an experimental randomized control trial, and the other five used a pre/post nonscientific design. All six studies found positive results from CPS. In the same article, the authors discussed unpublished evaluations and studies in settings that are directly relevant to juvenile justice involved youth. The authors point out that while CPS has been adopted in a number of child and adolescent treatment programs in the U.S., there were no published outcomes for residential treatment programs as of 2013.

Likewise, for juvenile justice settings—there were no published reports on outcomes. The same was true for school settings—there were no published studies by 2013, although four schools had completed evaluations that demonstrated favorable results for CPS. In the only subsequent published article on CPS outcomes since 2013, Pollastri, Lieberman, Boldt, and Ablon (2016) reported on a case study of a single multiservice youth mental health agency located in Oregon. Their article described the implementation of CPS in the agency, and the differences in clinical outcomes after a three year period. Significant improvements were realized in school functioning, self-harm, and thinking. Meaningful reductions in seclusion and restraints were also documented. Important qualitative data was also discussed regarding the hesitations and concerns from front line staff who were worried the CPS system would remove the only tools they had to enforce compliance.

There have been disruptions within the CPS organization that policy makers should be aware of. Dr. Ross Greene, the originator of CPS (Green, 1998) separated from CPS and Massachusetts General Hospital in 2008, and has publically denounced how CPS is being administered. Since 2013, Green has referred to his model as "Collaborative & Proactive Solutions" (www.cpsconnection.com). It is not known how this separation will affect the ongoing implementation of CPS in Oregon and other states.

*Summary:* In summary, CPS is a proprietary treatment model that addresses skill deficits in children and youth for the purposes of improving behaviors. The CPS model has been widely adopted in many areas, including the state of Oregon where a legislative mandate has required state treatment providers to spend a minimum of 75% of their tax dollars on "evidence based" treatments. While there is some evidence of CPS's effectiveness, there is scant evidence in the scientific literature supporting the proprietor's claims.

## ALTERNATIVE EDUCATION

Alternative schools and programs "are designed to address the needs of students that typically cannot be met in regular schools" (Carter & Lewis, 2010). Students attending alternative schools are there because they are at risk of educational failure, facilitated by low academic achievement, disruptive behavior, truancy, pregnancy, and other factors that cause temporary or permanent withdrawal from school. Common components of alternative education include small class size, high teacher-to-student ratios, individualized instruction, noncompetitive academic assessments, and less structured classroom environments (although there are different views regarding classroom structure) (OJJDP, 2000). This literature review will examine the current knowledge regarding non-secure alternative education settings, as opposed to secure detention educational settings, which

has its own distinct literature.

*Prevalence of Special Education Diagnoses:* Many youth enrolled in alternative education are also involved in the juvenile justice system, and many of those youth have documented disabilities such as emotional/behavioral disorder (EBD) that make them eligible for special education and related services under the federal Individuals with Disabilities Act (IDEA) (OJJDP, 2000). Estimates from one of the only national surveys of alternative schools indicated 11.5% of all students enrolled in alternative education settings are special education students with Individualized Education Programs (IEPs) (Kleiner, Porch, & Farris, 2002). This compares closely with U.S. Department of Education estimates indicating 12.1% of the entire nation's K – 12 students had disabilities in 2012-13.

Youth in the juvenile justice system are more likely to have diagnosed and undiagnosed disabilities compared with non-justice involved youth (OJJDP, 2000), with estimates ranging from 30% to 50% (Frieden, 2003). Most of the documented disabilities for juvenile justice involved youth are emotional/behavioral disabilities (about 46%), and about 40% have documented learning disabilities (Zabel & Nigro, 2001). There is evidence suggesting that the special education prevalence rates are even greater for serious and chronic youthful offenders. For example, Alltucker et al., (2006) found 58% of youth in an Oregon Youth Authority sample of 1,469 of previously incarcerated youth had a documented emotional disability (ED), and 36% had a documented learning disability (LD).

*Confusion About Enrollment Numbers:* There is some disagreement about how many students are enrolled in alternative education programs nationally. For example, the National Center for Education Statistics reported that in the U.S. during the school year 2007-08, there were 645,500 students enrolled in public school districts attending alternative schools and programs for at-risk students, with more than 95% of those programs serving high school aged students (grades 10 – 12) (Carter & Lewis, 2010). In contrast, Lehr, Tan, and Ysseldyke (2009) reported results from a national survey that indicated more than 1 million students were enrolled in alternative schools. Lehr, Tan, and Ysseldyke (2009) suggested the differences could be a result of different data collection procedures, definitions, and information sources.

The National Center for Education Statistics provided more granular estimates about the demographics of students participating in alternative education programs. Not surprisingly, most (56.7%) of the students were in large school districts with 10,000 students or more enrolled in the district. Nearly three quarters (70.5%) of the alternative education students lived in cities or suburbs located in the western states (43.0%). Students of color were overrepresented with 43.7% of students enrolled in alternative education settings coming from districts with 50% or more students of color. Students living in poverty were also overrepresented, with 78.3% of all alternative education students living in districts with 10% to 19% poverty concentration (Carter & Lewis, 2010). Within all the school districts with alternative school programs, 42% reported that youth involved in the juvenile justice system was one of the reasons students could be enrolled in the alternative program (Carter & Lewis, 2010).

In Oregon, alternative education is described by state law as a school or separate class group designed to meet the student's needs and interests and to achieve the academic standards of the district and the state (ORS 336.615). School districts in Oregon provide alternative education programs for students who need additional behavioral supports, are pregnant or are parenting, have been expelled

from school, have dropped out of school or who are at risk of dropping out of school, or who need additional supports to earn a diploma (Oregon Statewide Report Card, 2018). It is important to note that alternative education programs in Oregon also include "talented and gifted" (TAG) programs for students who need additional support because they are exceeding academic standards.

In 2018, 13,808 students in Oregon were enrolled in 209 alternative education programs. Most (83.0%) students were in grades 9 – 12. About two-thirds (67.8%) of those programs were designed for students with at-risk behaviors, and who needed remediation, credit recovery, or GED. The number of alternative education services directed towards students exhibiting risky behaviors, remediation, credit recovery, and GED (many of the characteristics of juvenile justice involved youth) has decreased 41.5% in recent years. For example, in 2014 there were 424 services compared with 248 services in 2018 (Oregon Statewide Report Card, 2018).

*Best Practices:* The characteristics of alternative education programs should be designed to help students achieve required educational goals in a manner consistent with their learning styles and needs (ORS 336.625). Those characteristics were outlined in Tobin and Sprague's (1999) widely cited article that summarized the following nine effective practices for use in alternative education settings:

- Low student to teacher ratio
- Highly structured classroom with behavioral classroom management
- Positive methods to increase appropriate behavior
- School-based adult mentor
- Functional behavioral assessment (FBA)
- Social skills instruction
- Effective academic instruction
- Parent involvement
- Positive behavioral interventions and support (i.e. Positive Behavioral Interventions and Supports)

*Lack of Empirical Evidence:* Despite the well documented need and substantial utilization of alternative education for juvenile justice involved youth, there is a lack of outcome evidence (OJJDP, 2001). Part of the reason is that alternative schools have changed significantly since their beginning, when they were viewed as punishment for undesirable behaviors and little emphasis was directed toward improving outcomes (Cox, 1999). In the early days, students with severe emotional and behavioral problems were funneled into alternative schools that were ill-equipped to handle the challenging behaviors and complex needs of the students (Arnove & Strout, 1980). More recently, Cox (1999) completed a study using experimental design to investigate the effects of an alternative school on reducing delinquent behaviors for at-risk youth. While the study found short-term improvements in grades, attendance, and self-esteem, there were no long-term effects after one year.

Other evaluations have found more positive results, for example a five year evaluation of OJJDP's alternative school model (the career academy) documented lower dropout rates, and a higher likelihood of completing the alternative school courses, and higher likelihood of applying for college (Kemple & Snipes, 2000).

*Street Smarts versus Book Smarts:* There is an interesting thread in the literature suggesting a dichotomy of youth perceptions about the value of traditional education. Hatt (2007) suggested that for some racially and economically

segregated youth, traditional schools represented oppressive social structures that were not working to support the youth. Hall suggested that many marginalized youth value "street smart" over "book smart" because street smarts allowed them to successfully navigate the social systems in their lives such as poverty, law enforcement, street culture, and violence, whereas "book smarts" did not help them maneuver though these structures. This dichotomy is formed during elementary school years when many youth of color and other marginalized groups form their educational identity—often feeling not smart through the practices of normal public education. Students who conform with behavioral expectations, perform well on tests, and take advanced classes develop their educational identities around being "book smart."

At the same time, educational identities for students who do not meet behavioral expectations and who do not perform well academically are being formed. For these youth, knowledge gained through academic books or school curricula is valued less than acquiring "street smarts" that are much more useful in their everyday lives. Hall went on to point out that schools should explore ways to blend "street smarts" with "book smarts" in order to honor the marginalized youths' cultural identities. This blending could be accomplished with a "people-based" approach to teaching that is more process oriented rather than assessment oriented.

*Summary:* In summary, alternative schools are designed to meet the needs of students who, for a variety of reasons, do not succeed in typical educational settings. Many youth involved in the juvenile justice system are also enrolled in alternative schools because they have emotional, behavioral and learning disabilities that have influenced their involvement in both systems. The common characteristics of alternative schools for juvenile justice involved youth are small class sizes, individualized instruction, low student-to-teacher ratios, and positive classroom environments that are geared towards serving the needs of the youth. Despite the widespread use of alternative schools for juvenile justice involved youth, there is a lack of outcome studies that demonstrate long-term improvements for youth.

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11

# APPENDICES

## THE PROGRAM EVALUATION STANDARDS

*Utility Standards*

The utility standards are intended to increase the extent to which program stakeholders find evaluation processes and products valuable in meeting their needs.

U1 Evaluator Credibility Evaluations should be conducted by qualified people who establish and maintain credibility in the evaluation context.

U2 Attention to Stakeholders Evaluations should devote attention to the full range of individuals and groups invested in the program and affected by its evaluation.

U3 Negotiated Purposes Evaluation purposes should be identified and continually negotiated based on the needs of stakeholders.

U4 Explicit Values Evaluations should clarify and specify the individual and cultural values underpinning purposes, processes, and judgments.

U5 Relevant Information Evaluation information should serve the identified and emergent needs of stakeholders.

U6 Meaningful Processes and Products Evaluations should construct activities, descriptions, and judgments in ways that encourage participants to rediscover, reinterpret, or revise their understandings and behaviors.

U7 Timely and Appropriate Communicating and Reporting Evaluations should attend to the continuing information needs of their multiple audiences.

U8 Concern for Consequences and Influence Evaluations should promote responsible and adaptive use while guarding against unintended negative consequences and misuse.

*Feasibility Standards*

The feasibility standards are intended to increase evaluation effectiveness and efficiency.

F1 Project Management Evaluations should use effective project management strategies.

F2 Practical Procedures Evaluation procedures should be practical and responsive to the way the program operates.

F3 Contextual Viability Evaluations should recognize, monitor, and balance the cultural and
political interests and needs of individuals and groups.

F4 Resource Use Evaluations should use resources effectively and efficiently.

*Propriety Standards*

The propriety standards support what is proper, fair, legal, right and just in evaluations.

P1 Responsive and Inclusive Orientation Evaluations should be responsive to stakeholders and their communities.

P2 Formal Agreements Evaluation agreements should be negotiated to make obligations explicit and take into account the needs, expectations, and cultural contexts of clients and other stakeholders.

P3 Human Rights and Respect Evaluations should be designed and conducted to protect human and legal rights and maintain the dignity of participants and other stakeholders.

P4 Clarity and Fairness Evaluations should be understandable and fair in addressing stakeholder needs and purposes.

P5 Transparency and Disclosure Evaluations should provide complete descriptions of findings, limitations, and conclusions to all stakeholders, unless doing so would violate legal and propriety obligations.

P6 Conflicts of Interests Evaluations should openly and honestly identify and address real or perceived conflicts of interests that may compromise the evaluation.

P7 Fiscal Responsibility Evaluations should account for all expended resources and comply with sound fiscal procedures and processes.

*Accuracy Standards*

The accuracy standards are intended to increase the dependability and truthfulness of evaluation representations, propositions, and findings, especially those that support interpretations and judgments about quality.

A1 Justified Conclusions and Decisions Evaluation conclusions and decisions should be explicitly justified in the cultures and contexts where they have consequences.

A2 Valid Information Evaluation information should serve the intended purposes and support valid interpretations.

A3 Reliable Information Evaluation procedures should yield sufficiently dependable and consistent information for the intended uses.

A4 Explicit Program and Context Descriptions Evaluations should document programs and their contexts with appropriate detail and scope for the evaluation purposes.

A5 Information Management Evaluations should employ sys-

tematic information collection, review, verification, and storage methods.

A6 Sound Designs and Analyses Evaluations should employ technically adequate designs and analyses that are appropriate for the evaluation purposes.

A7 Explicit Evaluation Reasoning Evaluation reasoning leading from information and analyses to findings, interpretations, conclusions, and judgments should be clearly and completely documented.

A8 Communication and Reporting Evaluation communications should have adequate scope and guard against misconceptions, biases, distortions, and errors.

### *Evaluation Accountability Standards*

The evaluation accountability standards encourage adequate documentation of evaluations and a metaevaluative perspective focused on improvement and accountability for evaluation processes and products.

E1 Evaluation Documentation Evaluations should fully document their negotiated purposes and implemented designs, procedures, data, and outcomes.

E2 Internal Metaevaluation Evaluators should use these and other applicable standards to examine the accountability of the evaluation design, procedures employed, information collected, and outcomes.

E3 External Metaevaluation Program evaluation sponsors, clients, evaluators, and other stakeholders should encourage the conduct of external metaevaluations using these and other applicable standards.

## STATE OF OREGON BRS PROVIDER REVIEW

BRS Provider Review

Name of Program: *Lane County Phoenix Program*

Date: 9/10/18

Reviewer(s): Karri Robinson, Ed Wyller, Eric Barrera

**Introduction:**

The Department of Human Services and Oregon Youth Authority monitor, review, and evaluate Behavior Rehabilitation Services being offered by BRS Contractors for compliance with Oregon Administrative Rule and individual Agency contracts.

Compliance in each area is determined by means of a thorough review of files, including personnel, open and closed client case files, and agency policies and procedures. For each sub- item that is specifically documented in the Oregon Medicaid State Plan there is an expectation for 100% compliance. For all other sub-items a pattern of compliance is determined by demonstration of a minimum of 90% compliance. The overall domain is determined to be in compliance when every sub-item shows a pattern of compliance.

Noted below are all areas reviewed with the corresponding compliance level. Lane County Phoenix Program is in compliance in all areas, therefore there will be no corrective action and follow-up.

| 1. PERSONNEL/PROGRAM REQUIREMENT-OAR 410-170-0030 | **In Compliance** |
|---|---|
| Standard: Program staff members meet BRS position requirements for education and experience.<br>Standard: Position Descriptions describe the duties and qualifications for each BRS position. | |
| 1.1 Program Coordinator credentials | In Compliance |
| 1.2 Program Coordinator position | In Compliance |
| 1.3 Social Service Staff credentials | In Compliance |
| 1.4 Social Service position | In Compliance |
| 1.5 Direct Care Staff credentials | In Compliance |
| 1.6 Direct Care Staff position | In Compliance |
| 1.7 Criminal History Checks | Pattern of Compliance |
| 1.8 All staff who work directly with BRS clients training – 28 hours within 30 days including: | Pattern of Compliance |
| BRS Service Documentation | Pattern of Compliance |
| Mandatory Reporting of Child Abuse | Pattern of Compliance |
| Program Policies and Expectations | Pattern of Compliance |
| Gender- and cultural-specific services | Pattern of Compliance |
| Behavior and crisis management | Pattern of Compliance |
| Medication administration | Pattern of Compliance |
| Discipline and restraint policies | Pattern of Compliance |

| | | |
|---|---|---|
| Suicide prevention | Pattern of Compliance | |
| 1.9 Receive 16 hours of training annually which must include: | Pattern of Compliance | |
| Skills-training curriculum supporting evidence-based or promising practices | Pattern of Compliance | |
| Other relevant subjects related to the delivery of BRS services | Pattern of Compliance | |
| 1.10 Comply with the provider enrollment requirement in OAR 410-120-1260 | In Compliance | |
| 1.11 Maintains a system for immediate and on-going communication amongst program staff regarding the whereabouts, status and condition of the youth | Pattern of Compliance | |
| 1.12 Direct Care Staff, Social Service Staff and Program Coordinator have and/or maintain a First Aid certification | Pattern of Compliance | |
| 1.13 Direct Care Staff, Social Service Staff and Program Coordinator have and/or maintain a CPR certification | Pattern of Compliance | |
| 1.14 BRS Contractor's Supervision of the Approved Provider Parent must include: | | |
| Visits to the Provider Parent home a minimum of one time each month | Not Applicable | |
| Provides 24 hour back up services I.E. on call services, consultation and direct crisis counseling | Not Applicable | |
| Provides an opportunity for 48 hours of respite care per month | Not Applicable | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 2. MINIMUM DIRECT CARE STAFFING LEVELS (0030) | **In Compliance** | |
|---|---|---|
| Standard: Program provides supervision consistent with the OAR 410-170-0030 for their specific level of care. (0030-b = TFC), (0030-c = Residential), | | |
| | Pattern of Compliance | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 3. INTAKE PROCEDURES (0040-0050) | **In Compliance** |
|---|---|
| 3.1 Admissions: Prior Authorization (0040-2) | In Compliance |
| 3.2 Admission decision is made within 5 days of receiving the referral packet. (0050-7) | Pattern of Compliance |
| 3.3 On the day that the BRS Client is physically admitted to the program, the provider will provide to the client and applicable parent, guardian or legal custodian copies of the following and maintain signed documentation that they have done so in each client's file. If the parent or guardian cannot be present provider may show documentation of forward of the policy by facsimile or mail within 48 hours. (0050-8-a) | Clients Pattern of Compliance<br>Adults Pattern of Compliance |
| Behavior management system policy | Pattern of Compliance |
| Grievance Policy | Pattern of Compliance |

| | | |
|---|---|---|
| Client and family rights | Pattern of Compliance | |
| Discharge policies | Pattern of Compliance | |
| Seclusion policy | Pattern of Compliance | |
| Suicide prevention policy and procedures | Pattern of Compliance | |
| Medication management policy | Pattern of Compliance | |
| Review Notes:<br>3.1 Missing BRS authorization for NL | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 4. INITIAL SERVICE PLANNING (0070-1) | **In Compliance** |
|---|---|
| 4.1 ISP Completed by Social Service staff within 2 business days | Pattern of Compliance |
| 4.2 Maintain the signatures of all participants or documentation that the client, family, caseworker, social service staff and other significant persons participated in or were invited to participate in the development of the ISP | Pattern of Compliance |
| 4.3 Written approval of the ISP prior to implementation from the Caseworker and Client and as applicable the parent, guardian, or legal custodian | Pattern of Compliance |
| 4.4 ISP is individualized and developmentally appropriate | Pattern of Compliance |
| 4.5 ISP is based on a thorough assessment of the client's referral information | Pattern of Compliance |
| 4.6 ISP specifies services for first 45 days | Pattern of Compliance |
| 4.7 Plan to address specific behaviors including intervention to be used | Pattern of Compliance |
| 4.8 Plan for any overnight visits | Pattern of Compliance |
| 4.9 Anticipated discharge date | Pattern of Compliance |
| 4.10 Anticipated type of discharge placement | Pattern of Compliance |
| 4.11 A plan to address any needs identified in the referral information. | Pattern of Compliance |
| 4.12 Existing orders medications/treatments | Pattern of Compliance |
| 4.13 Any type of behavior management system that will be used as an intervention | Pattern of Compliance |
| 4.14 Specific behavior management needs | Observation |
| Review Notes:<br>4.14 We recommend explaining what the various Risk Levels mean. | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
| • Action plan: Click here to enter text. | • Click here to enter text. | • Click here to enter text. |
| • Follow up notes (if needed): Click here to enter text. | | |

| 5. ASSESSMENT AND EVALUATION REPORT AER (0070-2) | In Compliance | |
|---|---|---|
| 5.1 Submit the complete written Assessment to the Caseworker within 30 days | Pattern of Compliance | |
| 5.2 Ensure that a Social Service Staff Member conducts a comprehensive assessment of the BRS Client and completes a written AER | Pattern of Compliance | |
| 5.3 The AER must include information with regard to the following domains: | | |
| Legal custody and basis for custody/Offense specific | Pattern of Compliance | |
| Medical (including medications & dosages) | Pattern of Compliance | |
| Family including specific cultural factors | Pattern of Compliance | |
| Mental Health | Pattern of Compliance | |
| Alcohol and Drug | Pattern of Compliance | |
| Education | Pattern of Compliance | |
| Vocational (if age appropriate) | Pattern of Compliance | |
| Social Living Skills | Pattern of Compliance | |
| Placement planning including home visits, anticipated discharge, and placement resources. | Pattern of Compliance | |
| Also includes: | | |
| 5.4 Reason for referral/placement (including identified problems and historical information) | Pattern of Compliance | |
| 5.5 Behaviors/response to current services, strengths and assets | Pattern of Compliance | |
| 5.6 Significant incidents and/or interventions since admission | Pattern of Compliance | |
| 5.7 Behavior management level needed, specifically any behavior management needs greater than usual for the program. | Pattern of Compliance | |
| 5.8 Identification of any service goals | Pattern of Compliance | |
| 5.9 Identified needs by assessment and history | Pattern of Compliance | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 6. Master Service Plan (0070-3) | In Compliance |
|---|---|
| 6.1 Master Service Plan completed by Social Service staff within 45 days | Pattern of Compliance |
| 6.2 MSP is individualized and developmentally appropriate | Pattern of Compliance |
| 6.3 Maintain the signatures of all participants or documentation that the client, family, caseworker, social service staff and other significant persons participated in or were invited to participate in the development of the MSP | Pattern of Compliance |
| 6.4 Written approval or the updated MSP prior to implementation from the Caseworker, client and as applicable the parent, guardian, or legal custodian | Pattern of Compliance |
| 6.5 Domains with indicated need are addressed. (Refer to 5.3) | Pattern of Compliance |
| 6.6 Placement plans including home visits, anticipated discharge date and placement resources. | Pattern of Compliance |

| | | |
|---|---|---|
| 6.7 Other needs identified in the AER that do not fall in one of the identified domains. | Pattern of Compliance | |
| 6.8 Completion criteria individualized for each client. | Pattern of Compliance | |
| 6.9 Specifically stated and prioritized service goal(s). (Describe youth's desired accomplishment in the domain upon completion of program.) | Pattern of Compliance | |
| 6.10 Interventions and services program will provide to address each goal, including the use of a behavior management system specific group, counseling and skill-building curriculums. | Pattern of Compliance | |
| 6.11 Staff responsible for providing the identified services | Pattern of Compliance | |
| 6.12 Specifically stated behavioral criteria for evaluating the achievement of goals. | Pattern of Compliance | |
| 6.13 A time frame for completion of goals | Pattern of Compliance | |
| 6.14 The method used to monitor progress towards completing goals and the person responsible for monitoring progress. | Pattern of Compliance | |
| 6.15 Aftercare/transition goals and planning | Pattern of Compliance | |
| 6.16 Description of services by other providers including needs to be addressed | Pattern of Compliance | |
| Also includes, where applicable: | Choose an item. | |
| 6.17 Behavior management level needed, specifically any behavior management needs greater than usual for the program. | Pattern of Compliance | |
| 6.18 Planning for when overnight visits are to occur, identifying frequency, and describing how the visits relate to the BRS goals identified in the MSP. The program must make every attempt to schedule visits so that they do not conflict with services. | Pattern of Compliance | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 7. Master Service Plan Update/Review (0070-4) | **In Compliance** |
|---|---|
| 7.1 Formal service plan review meetings occur at least every 90 days | Pattern of Compliance |
| 7.2 Maintain the signatures of all participants or documentation that the client, family, caseworker, social service staff and other significant persons participated in or were invited to participate in the development of the MSP update | Pattern of Compliance |
| 7.3 Written approval or the updated MSP prior to implementation from the Caseworker, client and as applicable the parent, guardian, or legal custodian | Pattern of Compliance |
| 7.4 Review documents include: | Choose an item. |
| Progress toward achievement of service goals | Pattern of Compliance |
| Performance on the behavior management system | Pattern of Compliance |
| Performance on any individualized plans developed to address specific behavior | Pattern of Compliance |
| Modifications to services based on new behaviors or identified needs | Pattern of Compliance |
| Changes in recommendations, discharge date, or transition/discharge plan | Pattern of Compliance |
| A summary of incidents involving the Client that occurred over the last 90 days | Pattern of Compliance |
| Review Notes: Click here to enter text. | |

| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 8. TRANSITION/AFTERCARE PLAN (0070-5) | **In Compliance** |
|---|---|
| 8.1 Maintain the signatures of all participants or documentation that the client, family, caseworker, social service staff and other significant persons participated in or were invited to participate in the development of the ATP update | Pattern of Compliance |
| 8.2 Social Service staff completes a written ATP at least 30 days prior to or as close as possible to the client's planned discharge | Pattern of Compliance |
| 8.3 Written approval or the initial and final ATP prior to implementation from the Caseworker, client and as applicable the parent, guardian, or legal custodian | Pattern of Compliance |
| 8.4 Plans describe how the client will successfully transition from the program to the community, specifically addressing the period of 90 days after discharge. | Pattern of Compliance |
| 8.5 Plan supports youth efforts to return home or transition to other setting | Pattern of Compliance |
| 8.6 Aftercare plan identifies needs and unmet goals | Pattern of Compliance |
| 8.7 Identification of services and supports outside of the program that will be available for the 90 day period. | Pattern of Compliance |
| 8.8 Plan identifies person or entity responsible for providing the aftercare services. | Pattern of Compliance |
| 8.9 Aftercare plan identifies person or agency responsible for providing aftercare services | Pattern of Compliance |
| 8.10 Schedule for regular telephone contact with the client and as applicable the family, caseworker, or other identified significant persons. | Pattern of Compliance |
| Review Notes: Click here to enter text. | |

| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 9. DISCHARGE SUMMARY (0070-6) | **In Compliance** |
|---|---|
| 9.1 Discharge summary completed and provided to the Caseworker within 15 days following the planned or actual discharge. | Pattern of Compliance |
| 9.2 Discharge summary discusses progress toward service plan goals | Pattern of Compliance |
| Review Notes: Click here to enter text. | |

| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |

| | |
|---|---|
| Follow up notes (if needed): Click here to enter text. | |

| 10. AFTERCARE SUMMARY (0070-7) | In Compliance | |
|---|---|---|
| 10.1 Aftercare summary completed and provided to the Caseworker no later than 120 days following the client's discharge form the program. | Pattern of Compliance | |
| 10.2 Summarizes the status and progress on the ATP for the 90 days following discharge from the program. | Pattern of Compliance | |
| 10.3 Aftercare summary describes the clients adjustment in community | Pattern of Compliance | |
| 10.4 Aftercare summary includes any further recommendations | Pattern of Compliance | |
| Review Notes: These looked great! | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 11. SERVICE DOCUMENTATION (0090) | In Compliance | |
|---|---|---|
| 11.1 Provide a combination of services necessary to comply with the clients ISP or MSP. | Pattern of Compliance | |
| 11.2 Documentation included | Choose an item. | |
| Name of Client | Pattern of Compliance | |
| Date of service | Pattern of Compliance | |
| Name and position of the staff member providing the service | Pattern of Compliance | |
| Length of time staff spent providing the service to the client | Pattern of Compliance | |
| Description of the service being provided | Observation | |
| Description of the clients participation in the service | Pattern of Compliance | |
| 11.3 Written weekly record in each client's file with a total number of service hours provided each day to the client and a breakdown of the number of hours spent providing each particular type of service (i.e., Crisis counseling, individual and group counseling, parent training, skills training) | Pattern of Compliance | |
| 11.4 Social service staff review the documentation each week for quality, content and appropriateness with the client's ISP or MSP. | Pattern of Compliance | |
| 11.5 BRS Basic Residential - 11 hours of services are available to each client each week. To include: Crisis Counseling, Individual Counseling, Group Counseling, Milieu Therapy, Parent Training, Skills Training | Pattern of Compliance | |
| 11.6 1 hour individual counseling/skill training per week provided by Social Service staff. | Pattern of Compliance | |
| 11.7 1 additional hour individual counseling/skill training per week all (except Shelter, ICC, ILS, Community Step Down) | Pattern of Compliance | |
| 11.8 Choose from list hours of any combination of individual or group counseling, crisis counseling, skills training or parent training. | Pattern of Compliance | |
| Review Notes:<br>11.2 Description of services provided: Facilitated Diversity Group focusing on racism. Focusing on stereotype problem solving. Some notes were rather illegible | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |

| | | |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| | |
|---|---|
| 12. INCIDENT REPORTS (0030-11-B) Maintain a record of all incidents and crisis interventions including but not limited to communication outages, use of seclusion and physical restraint, a risk to the status or custody of the client or other incidents likely to cause complaints, generate safety, programmatic or other serious concerns, or come to the attention of the media, or law enforcement. All reports will contain the following | **In Compliance** |
| 12.1 Name of the client | Pattern of Compliance |
| 12.2 The date, location and type of incident or crisis intervention. | Pattern of Compliance |
| 12.3 The duration of any seclusions or physical restraints employed in the context of the incident. | Pattern of Compliance |
| 12.4 Name of staff involved in the incident or crisis intervention, including the names of any witnesses. | Pattern of Compliance |
| 12.5 Description of the incident or crisis intervention, including precipitating factors, preventative efforts employed, and description of circumstances during the incident. | Pattern of Compliance |
| 12.6 Physical injuries to the client or others resulting from the incident or crisis intervention, including information regarding any follow-up medical care or treatment. | Pattern of Compliance |
| 12.7 Documentation showing that any necessary reports were made to the appropriate agency, any other entity required by law to be notified, and as applicable the clients parent guardian or legal custodian. | Pattern of Compliance |
| 12.8 Documentation indication the date that a copy of the incident report was sent to the caseworker. | Pattern of Compliance |
| 12.9 Actions or interventions taken by program staff. | Pattern of Compliance |
| 12.10 Any follow-up recommendations for the client or the staff. | Pattern of Compliance |
| 12.11 Any follow-up or investigation conducted by the provider supervisory staff, DHS, OYA or other entities. | Pattern of Compliance |
| 12.12 The providers review of the incident or crisis intervention. | Pattern of Compliance |
| Review Notes: Couldn't see that a copy of the incident report was sent to caseworker | |

| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| | |
|---|---|
| 13 Home visits (0100-4) | **In Compliance** |
| In order to qualify as an authorized home visit the provider must: | |
| 13.1 Ensure that the home visit is tied to the clients ISP or MSP | Pattern of Compliance |
| 13.2 Work with the family on goals for the visit and receive regular reports from the family on the client's progress while on the home visit. | Pattern of Compliance |
| 13.3. Have staff available to answer calls from the client or the client's family and to provide services to the client during the time planned for the home visit if the need arises | Pattern of Compliance |
| 13.4 Document communication with the client's family. | Pattern of Compliance |

| | | |
|---|---|---|
| 13.5 Document client's progress on goals set for the home visit. | Pattern of Compliance | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 14 Policies (0030-10) | **In Compliance** |
|---|---|
| 14.1 Admission criteria and standards to accept a BRS client into the program. | Pattern of Compliance |
| 14.2 Staff training, including child abuse reporting. | Pattern of Compliance |
| 14.3 Reviewing referrals to the program and notification of admission decisions. | Pattern of Compliance |
| 14.4 Behavior management system policy designed to consistently encourage and positively reinforce appropriate behaviors exhibited by the clients in a non-punitive manner. | Pattern of Compliance |
| 14.5 A behavioral rehabilitation program model that uses evidence-based or promising practices whenever possible and the curriculum, policies, and procedures which implements that model. | Pattern of Compliance |
| 14.6 Client and family rights, including but not limited to the search and seizure of the clients person, property and mail; visitation and communication; and discharges initiated by the client. | Observation |
| 14.7 Grievance policy describing the process through which the client and if applicable the parent, guardian or legal custodian may present grievances to the provider about its operation and resolve issues. | Pattern of Compliance |
| 14.8 Voluntary nature of BRS with a process that allows the client to leave the program with no more than 3 business days advance notice. (0060-1-a) | Pattern of Compliance |
| 14.9 Suicide prevention policy and procedure that includes how the provider will respond in the event a youth exhibits self-injurious/self-harm or suicidal behavior. This policy must include warning signs of suicide, emergency protocol and contacts, and training requirements for staff. | Pattern of Compliance |
| 14.10 Seclusion and Physical restraint policy that describes when such interventions may be used in compliance with applicable federal and state laws and regulations. It must be clear in the policy that if the restraint or seclusion are to be used as a intervention of last resort, it must describe how and by whom staff are trained and monitored in approved techniques. | Pattern of Compliance |
| 14.11 Medication management policy that describes how and where medications are stored, how a client will be notified of their right to refuse medication, and that the provider will notify the JPPO/ Caseworker if the client refuses prescribed medications for more than 7 days or refuses a medication that has been identified by any LPHA as requiring an immediate report for health care reasons. | Pattern of Compliance |
| 14.12 Quality Improvement policy and procedures that monitor the operation of the program to ensure compliance with all applicable laws and regulations, including but not limited to tracking of service hours, monitoring the timeliness or reporting requirements, and monitoring the quality of service delivery. | Pattern of Compliance |
| Review Notes:<br>14.6 Information about search and seizure of the clients person, property and mail is provided to youth and families at intake. It is documented on the "Consents, Disclosures, and Authorizations" form. | |
| Corrective Action Plan (To be completed by Program) | Person Responsible / Due Date |

| | | |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 15. Physical Facility (0030-9) | **In Compliance** | |
|---|---|---|
| 15.1 The environment is suitable for treatment of BRS clients | Pattern of Compliance | |
| 15.2 Meets all applicable safety, health, and general environmental standards required for a community residential or home setting. | Pattern of Compliance | |
| 15.3 Provide separate bedrooms for clients 18 and older from those 18 and younger unless there is written approval from Licensing and Agency. | Pattern of Compliance | |
| 15.4 Provide separate bedrooms for BRS clients who have inappropriate sexual behaviors identified in their service plan from those who do not. | Pattern of Compliance | |
| 15.5 Provide that BRS clients who have inappropriate sexual behaviors identified in their service plan occupy a bedroom either individually or in a group of 3. | Pattern of Compliance | |
| 15.6 Provide separate bedrooms for clients and other members of the household. | Not Applicable | |
| 15.7 Provide separate bedrooms for male and female clients | Pattern of Compliance | |
| 15.8 Provide physical separation of clients served in BRS program from person housed in detention facility or youth correction facility. | Pattern of Compliance | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

| 16. PLACEMENT RELATED ACTIVITIES 0100 | **In Compliance** | |
|---|---|---|
| 16.1 Transportation: A system in place for the following Placement Related Activities i.e. attend school, medical, dental and therapeutic appointments, recreational and community activities, places of employment and shopping for incidental items | Pattern of Compliance | |
| 16.2 Educational and vocational activities: Provider must have a system in place to meet the educational and vocational needs of the BRS client. | Pattern of Compliance | |
| 16.3Recreational, Social and Cultural activities: Provider must have a system in place to provide recreation time on a daily basis to include community opportunities at least 1 time per week. | Pattern of Compliance | |
| 16.4 Documentation included: | | |
| Type of activity | Pattern of Compliance | |
| Date activity occurred | Pattern of Compliance | |
| At least 1 activity per week in the community | Pattern of Compliance | |
| 16.5 Academic Assistance | Pattern of Compliance | |
| 16.6 Documentation of physical exam completed within 30 days of placement, if applicable. | Pattern of Compliance | |
| Review Notes: Click here to enter text. | | |
| Corrective Action Plan (To be completed by Program) | Person Responsible | Due Date |

| | | |
|---|---|---|
| Action plan: Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Follow up notes (if needed): Click here to enter text. | | |

**Summary:**

The Lane County Phoenix program is in compliance in 16 out of the 16 areas reviewed. Thank you for your cooperation during the review process.

| FILES REVIEWED | | |
|---|---|---|
| Client's Initials | Social Service Staff | Open / Closed |
| HW | CH | C |
| RW | CH | C |
| NL | CH | O |
| LO | VR | C |
| DC | CH | C |
| HW | CH | C |

BRS REVIEW CHECKLIST

Date of preparation material sent: 7/11/2018, KR

Date of review: 9/10/2018, KR

Date of report: 9/24/2018, KR

# PARENT/GUARDIAN CONSENT FORM

PARENT/GUARDIAN CONSENT FORM

PHOENIX PROGRAM EVALUATION

You are being asked to participate in an evaluation of the Phoenix Program. Your involvement is completely voluntary and it is up to you to choose whether to be involved or not. You can choose to participate, or decline. If you choose to participate and then decide later that you want to stop, that is fine. There will be no "penalty" or loss of services if you decide to stop at any time.

Purpose: The purpose of the Phoenix Program evaluation is to find ways to make the program better for the teenagers and families participating in the program

Duration: Your participation is expected to last approximately 30 minutes

Procedures and Activities: You will be asked to discuss your experiences with the Phoenix Program, or you can choose to describe your experiences with the Phoenix Program in writing

Risks: Some of the foreseeable risks or discomforts from your participation include risks of stress, emotional discomfort, and inconvenience

Benefits: There are no direct benefits to you for participating in the evaluation, however, it is hoped that information gained will help improve services and outcomes for youth and families participating in the Phoenix Program

Alternatives: Your participation is voluntary, so the only alternative is to not participate

Who is conducting the Phoenix Program evaluation? Kevin Alltucker, a Lane County Youth Services employee is conducting the evaluation

What are my Responsibilities if I decide to participate in this evaluation? If you choose to participate, you will be responsible for meeting with Kevin Alltucker for about 30 minutes and discussing your experiences with the Phoenix Program. Or, if you choose to describe your experiences in writing, Kevin will give you a questionnaire to complete

How will information be collected? If you agree to participate, Kevin will contact you to arrange a convenient time and place to meet for approximately 30 minutes. Kevin will ask you about your experiences with the Phoenix Program and will take notes during the interview. If you prefer to describe your experiences in writing instead of an interview, that option is available

How will my privacy and confidentiality be protected? In the written evaluation report, Kevin will not use any personally identifying information. For example, your name and your child's name will not be used in the report

What happens to the notes that Kevin Alltucker takes during the interview, or the written answers I provide? The notes from the interview will be kept behind locked doors at Lane County Youth Services, and will be destroyed after the final evaluation report is finished. If you provide written answers, those notes will also be kept behind locked doors at Lane County Youth Services, and

destroyed after the final evaluation report is finished

Will I be paid for my time spent participating in the evaluation? No, you will not receive payment for your time spent participating in the evaluation

Who can answer my questions about the Phoenix Program evaluation? You can contact Kevin Alltucker (email:Kevin.Alltucker@co.lane.or.us) or Youth Services Director Nathaline Frener (email: Nathaline.Frener@co.lane.or.us)

STATEMENT OF CONSENT

I have read and considered the information in this form. I have asked any questions necessary to make my decision about participating in the Phoenix Program evaluation. I understand that I can ask additional questions throughout my participation.

I understand that by signing below, I am volunteering to participate in this evaluation. I understand that I am not giving away any of my legal rights. I have been given a copy of this consent form.

I consent to participate in the Phoenix Program evaluation.

_____ _____

Name of Adult Participant Signature of Adult Participant Date

Best way for Kevin Alltucker to contact me:

email: _____

Phone: _____

Other:_____

# PARENT/GUARDIAN PERMISSION FORM FOR CHILD'S PARTICIPATION

PARENT/GUARDIAN PERMISSION FORM FOR CHILD'S PARTICIPATION

PHOENIX PROGRAM EVALUATION

Your child is being asked to participate in an evaluation of the Phoenix Program. Your child's participation is completely voluntary and it is up to you to decide whether you want your child to be involved or not. You can choose to allow your child to participate, or you can decline. If you choose to allow your child to participate and then decide later that you don't want your child to participate, that is fine. Even if you give permission for your child, your child might not want to participate. There will be no "penalty" or loss of services if you decide to not allow your child to participate in the evaluation, or if your child declines to participate

Purpose: The purpose of the Phoenix Program evaluation is to find ways to make the program better for the teenagers and families who are involved in the program

Duration: Your child's participation is expected to last about 30 minutes

Procedures and Activities: Your child will be asked to discuss their experiences with the Phoenix Program. If your child prefers to describe their experiences in writing instead of an interview, that option is available

Risks: Some of the foreseeable risks or discomforts that your child might experience include risks of stress, emotional discomfort, and inconvenience

Benefits: There are no direct benefits for your child's participation in the evaluation, however, it is hoped that information gained will help improve services and outcomes for youth and families participating in the Phoenix Program

Alternatives: Your child's participation is voluntary, so the only alternative is to not participate

Who is conducting the Phoenix Program evaluation?: Kevin Alltucker, a Lane County Youth Services employee is conducting the evaluation

What are my child's responsibilities if I agree they can participate?: If you choose to allow your child to participate in the evaluation, your child will be responsible for meeting with Kevin Alltucker for about 30 minutes to discuss their experiences with the Phoenix Program, or they can choose to describe their experiences in writing instead of an interview

How will information be collected?: If you agree to allow your child to participate in the program evaluation, Kevin Alltucker will work with Phoenix staff and your child to find a convenient time and place for the interview. Kevin will ask your child about their experiences in the Phoenix Program and will take notes. If your child prefers to describe their experiences in writing instead of an interview, that option is available

How will my child's privacy and confidentiality be protected?: In the written evaluation report, Kevin will not include any personally identifying information. For example, your child's name will not be used in the report. There is a situation when privacy and confidentiality will not be maintained and that is if your child threatens to harm themselves or others. In this situation, Kevin will inform the Phoenix Program on-site supervisor of the disclosure(s)

What happens to the notes that Kevin Alltucker takes during the interview with my child or the written responses my child provides?: The notes from the interview will be kept behind locked doors at Lane County Youth Services, and will be destroyed after the final evaluation report is finished. If your child chooses to describe their experiences in writing, those notes will be kept behind locked doors at Lane County Youth Services and destroyed after the final evaluation report is finished

Will my child be paid or otherwise rewarded for participating in the Phoenix Program evaluation?: No, your child will not be paid or rewarded for participating in the Phoenix Program evaluation

Who can answer my questions about the Phoenix Program evaluation?: You can contact Kevin Alltucker (email: Kevin.Alltucker@co.lane.or.us) or Youth Services Director Nathaline Frener (email: Nathaline.Frener@co.lane.or.us)

STATEMENT OF CONSENT

I have read and considered the information in this form. I have asked any questions necessary to make my decision about my child's participation in the Phoenix Program evaluation. I understand that I can ask additional questions throughout my child's participation

I understand that by signing below, I am agreeing that my child can participate in the Phoenix Program evaluation. I understand that I am not giving away any of my legal rights, or my child's legal rights. I have been given a copy of this consent form.

I agree that my child can participate in the Phoenix Program evaluation.

_____ _____ _____

Print name of parent/guardian Signature of parent/guardian Date

_____

Print name of child

# YOUTH ASSENT PERMISSION FORM

YOUTH ASSENT PERMISSION FORM

PHOENIX PROGRAM EVALUATION

My name is Kevin Alltucker, and I work for Lane County Youth Services. I am doing an evaluation of the Phoenix Program and I am asking you to consider participating so that your feedback can be used to improve the program.

What is the purpose of the program evaluation? The purpose of the program evaluation is to document the value of the program, and to find ways to make it better

Why is the Phoenix Program being evaluated? Lane County Youth Services is interested in making the program better for youth and families

Description of Your Involvement: If you agree to be a part of this evaluation, at least one of your parents/guardians must also give their permission for you to participate. You will talk with Kevin Alltucker for about 30 minutes about your experiences with the Phoenix Program. The interview will be in a convenient time and place for you. During the interview, Kevin will take notes. If you would rather describe your experiences in writing instead of an interview, that is fine—just tell Kevin which option you want (interview or writing)

Benefits: You won't receive any direct benefits by participating in the Phoenix Program evaluation, but it is hoped that the information you give will help improve the program for teenagers in the future

Risks and Discomforts: You might feel nervous or distressed, or you might feel stressed by discussing your experiences in the Phoenix Program. Sometimes answering questions can be uncomfortable, and you can choose not to answer a question or you can stop the interview at any time. Just tell Kevin that you want to stop the interview. If you choose the writing option and you don't feel like answering a question, you don't have to answer that question

Will information about me and my experiences be kept confidential? Yes—any information about you and your experiences with the Phoenix Program will be kept confidential. Someone reading the final evaluation report will not be able to identify who said what in the interviews or the written responses. There is one circumstance when confidentiality will not be maintained and that is if you tell or write Kevin that you are considering hurting yourself or someone else. In that situation, Kevin will tell the Phoenix Program on-site supervisor what you said or wrote

Will I get paid for participating in the Phoenix Program evaluation? No, you will not be paid

Do I have to participate in the Phoenix Program evaluation? No, you don't have to participate. Your participation is completely voluntary and you can choose to stop participating at any time. No one will be mad at you if you don't want to participate, and you won't be punished for not participating

What if I have questions? You can ask any Phoenix Program Group worker or Supervisor if you have questions, and they will contact Kevin Alltucker to get your questions answered for you

ASSENT OF ADOLESCENT (13 – 17 years old)

If you decide to participate and your parents/guardians agree, Kevin Alltucker will give you a copy of this form to keep.

If you would like to participate in the Phoenix Program evaluation, please print and sign your name on the line below.

| _____ | _____ | _____ |
|---|---|---|
| Adolescent's printed name | Adolescent's signature | Date |

## Acknowledgments

Many thanks to the entire staff at Lane County Youth Services for their assistance and patience during the evaluation. Special thanks to Lane County Youth Services Division Manager Nathaline Frener who allowed full access to the Phoenix Treatment Program and who also supported the evaluation work throughout the year-long process. Tai Pruce-Zimmerman's amazing Excel spreadsheet skills helped make short work of the utilization analyses. Jennifer Cearley, Ph.D. of Washington County Youth Services helped conceptualize some of the quantitative analyses.

An additional special acknowledgment goes to all of the dedicated professionals who work day and night with some of Lane County's most vulnerable youth, and who serve as positive role models every single day.

Finally, acknowledgments to the youth and their families who participated in the Phoenix Treatment Program--their efforts to improve their lives were profound.

## About the Cover

The young man on the cover of the evaluation report participated in the Phoenix Treatment Program and earned the opportunity to be on a work crew that maintained local trails and recreation areas

## About the Evaluator

Kevin Alltucker, Ph.D. has worked with the Lane County Youth Services Phoenix Treatment Program on and off through the years since the program started in 2005. During the evaluation he was employed by Lane County Youth Services. Questions or comments can be directed to: Kevin.Alltucker@co.lane.or.us

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